

REC'D MAR 21 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

7579
Do not use this space.

1. PLACE OF DEATH

(a) County Ralls 2 Registration District No. 726
(b) Township Spencer Primary Registration District No. 5957
(c) City New London (d) Street No. _____ St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

260 NANCY HOUSEY
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 6 4 16

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Homekeeper
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

FATHER 13. NAME Beaton Housey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER 15. MAIDEN NAME Sally Clark
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Minnie Clayton

18. BURIAL, CREMATION, OR REMOVAL PLACE New London, Mo. DATE Feb. 24 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. B. Clark

20. FILED 323 1939 Blanche Myron Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 22 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1939, to Feb 22 1939. I last saw him alive on Feb 20 1939. Death is said to have occurred on the date stated above, at 5:26 p.m.
The principal cause of death and related causes of importance were as follows:

Myocarditis

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) M. J. Waters M. D.
(Address) New London, Mo.

RECEIVED

District Health Officer No. 10

District File Number 10-39-404

Date Filed MAR 10 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

J. B. Clark and Clyde Wielke, or by

Registered Apprentice No., working under my personal supervision.

Signed

J. B. Clark

Licensed Embalmer No. 2154

P. O. Address Wandavia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

75-79
Do not use this space.

1. PLACE OF DEATH

(a) County Ralls Registration District No. 726
(b) Township Spencer Primary Registration District No. 3987
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred, yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nancy Kousner

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 8

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 > 22 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-6" 1895

I last saw h _____ alive _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 4 16

Date of onset _____
Other contributory causes of importance: _____

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

FATHER 13. NAME _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Feb 23 1939 Blanche Neeson Local Registrar.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) H. G. Waters, M. D.
(Address) New London Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

