

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1939 NOV 18 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35406

Do not use this space.

1. PLACE OF DEATH

(a) County Barry Registration District No. 992
 (b) Township Osage Primary Registration District No. 5047
 (c) City Osage (d) Street No. _____

Registered No. Six

(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

(a) Residence, No. 250 Susan Akin St. Osage
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Osage Akin (Deceased)
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS 95 MONTHS 2 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 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. Homemaker
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Tenn. (STATE OR COUNTRY) 1

FATHER 13. NAME Russell Walters 1

14. BIRTHPLACE (CITY OR TOWN) Tenn. (STATE OR COUNTRY) 1

MOTHER 15. MAIDEN NAME Margaret Mayhew

16. BIRTHPLACE (CITY OR TOWN) Tenn. (STATE OR COUNTRY)

17. INFORMANT Mrs. H. A. Ellis (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE Tenn. DATE Oct 24 1939

19. FUNERAL DIRECTOR (NAME) Osage Funeral Home (ADDRESS) 221 West Church St. Osage

20. FILED Oct 25 1939 Dow Brichbuhler Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 28, 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1939, to Oct 22, 1939

I last saw him alive on Oct 28, 1939 Death is said

to have occurred on the date stated above, at 2:15 p.m.

The principal cause of death and related causes of importance were as follows:

Senility Date of onset _____

Other contributory causes of importance: _____

RECEIVED

District Health Officer No. 6,

District File Number 1139-2170

Date Filed NOV 6 1939

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, or by.....

Myself....., Registered Apprentice No.....
working under my personal supervision.

Signed Osca Marsh

Licensed Embalmer No. 3812

P. O. Address Aurora Mo

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

35-406

Do not use this space.

1. PLACE OF DEATH

(a) County Barry Registration District No. 992
(b) Township Paris Primary Registration District No. 3047 Registered No. 219
(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 Susan Miller

(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

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 16 1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
95 2 7

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)

13. NAME

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

15. MAIDEN NAME

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 Oct 25 1939 Don Brechbuhler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from

19 _____, 19 _____
I last saw him alive on _____, 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:

Date of onset

Other contributory causes of importance:

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) J. Will Smith, M. D.

(Address) Aurora

