

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

36225  
Do not use this space.

1. PLACE OF DEATH

(a) County Howard Registration District No. 378  
(b) Township \_\_\_\_\_ Primary Registration District No. 4222 Registered No. 68  
(c) City Fayette (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

(a) Residence, No. 380 Amanda White 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 <b>Female</b>	4. COLOR OR RACE <b>Black</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>William White</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>4/7th 1867</u>		
7. AGE YEARS <u>72</u>	MONTHS <u>6</u>	DAYS If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>At home</u>		
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) <u>Missouri</u>		
13. NAME <u>Thomas Cosby</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
15. MAIDEN NAME <u>Emma Monroe</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
17. INFORMANT (ADDRESS) <u>William White, Fayette, Mo.</u>		
18. BURIAL, CREMATION, OR DISPOSAL PLACE <u>City Cemetary</u> DATE <u>10/7th 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Guy T. Halley, Fayette, Mo.</u>		
20. FILED <u>Nov 5 1939</u> <u>V. O. Bonham</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/7th 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 15 1939, to 10-7 1939  
I last saw her alive on 10-7-39. 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:  
Hypostatic Pneumonia  
Septic Vascular Rema  
Sepsis  
Seremic Coma  
Date of onset 10-4-39

Other contributory causes of importance: Arteriosclerosis  
121  
Sept 1939

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? none 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 \_\_\_\_\_  
Cause of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) Dr. Bloom, M. D.  
Fayette, Mo. (Address)

FEB 17 1949

RECEIVED  
District Health Officer No. 8,  
District File Number "17/39"  
Date Filed

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**