

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37399

Registration District No. 846 Primary Registration District No. 6105 Registrar's No. 11

1. PLACE OF DEATH:  
(a) County Stone  
(b) City or town Rural Cherry Mountain  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 62 yrs years, months or days

3. (a) PRINT FULL NAME MATTIE MICHEL  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife Herman Michel  
6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased MAR 18 1897  
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 26 If less than one day hr. min.

9. Birthplace MISSOURI (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name John Brown

13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name MARY JANE HASTITER

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Herman Michel

(b) Address Marionville

17. (a) \_\_\_\_\_ (b) Date thereof Oct 12 39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marionville

18. (a) Signature of funeral director A. J. Wallace

(b) Address Billings, Mo

19. (a) 11-10-39 (b) A. G. Shinn  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Stone  
(c) City or town Marionville (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day Thursday  
year 39 hour 12 minute 12 M.

21. I hereby certify that I attended the deceased from Oct. 1, 1939, 1939, to Oct 12, 1939; that I last saw her alive on Oct. 11, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Pellegra  
Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_

23. Signature Dr. Wayne M. Weaver (M. D. or other)  
Address Marionville, Mo Date signed 10/12/39

Duration 2 yrs.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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.

RECEIVED

District Health Officer No. 6,

District File Number 1139-2355

Date Filed NOV 14 1939

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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.....

Everett R. Head

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Everett R. Head

Licensed Embalmer No. 4038

P. O. Address Billings, 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.