

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40995

Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 837
 (b) Township Caster Primary Registration District No. 6099 Registered No. _____
 (c) City Bloomfield, Mo., R.F.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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Mary Josephine Kounius

(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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-18-1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 11 29

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

12. BIRTHPLACE (CITY OR TOWN) Stoddard Co. Mo. (STATE OR COUNTRY) Mo.

FATHER 13. NAME David Mays

14. BIRTHPLACE (CITY OR TOWN) Not known (STATE OR COUNTRY) Not known

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) Not known (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) Mrs Elmer Aslin
Bloomfield Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty Cem. DATE 11-19 1939

19. FUNERAL DIRECTOR (NAME) Chilesund Co. (ADDRESS) Bloomfield Mo.

20. FILED Nov 27 1939 Loonie Purich Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-17 1939

22. I HEREBY CERTIFY, That I attended deceased from June 10 1939 to Nov 17 1939

I last saw her alive on Nov 5 1939 Death is said to have occurred on the date stated above, at 9:50 p.m.

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

Fractured Hip from
accidental fall

Date of onset

6-10-39

Other contributory causes of importance: 180 lbs
10

Name of operation None 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 Fractured Hip in accidental

Nature of injury fall

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify (Signed) S. S. Harris, M. D.

(Address) Weller mid

RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT

DATE 11.27.37

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 with the above constitutes grounds for revocation of license.)

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

