

RECEIVED

District Health Office

District File Number 340

Date Filed 3/11/88

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 Hunter Albritton

Licensed Embalmer No. 2940

P. O. Address Biloxi Bluffs

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.

Registration District No. **839**

Primary Registration District No. **6101**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Stoddard**
(b) City or town **Richland, S.P.**
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ years, months or days)

3. (a) PRINT FULL NAME

Margie Artis

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **e** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years **56** Months **11** Days **23** If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **1-1-41** (b) **J.P. Brandon** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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 **2** day **7** year **1970** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (e) Means of injury _____

23. Signature **S.P. Davis** (M. D. or other) _____

Address **Depta new** Date signed _____

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A P. 5 MANE. RECORD

MAY 17 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 83793

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 839

Primary Registration District No. 6101

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Richland T. P.
(If outside city or town limits, write "RURAL" and name of township)
(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.....
years, months or days)

3. (a) PRINT FULL NAME

Margie Artis

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex 7 5. Color or race col 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 11 22 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... County.....
(c) City or town..... (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 2 day 7
year..... hour..... minute..... M.

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that I last saw him..... alive on....., 19.....;
and that death occurred on the date and hour stated above.
Immediate cause of death.....

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?
..... (Specify type of place)

While at work..... (e) Means of injury.....

23. Signature S. S. Davis (M. D. or other).....

Address Depler mo Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL