

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

DEC 5 - 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38268

Registration District No. 95 Primary Registration District No. 5237 Registrar's No.

1. PLACE OF DEATH:

(a) County BUTLER MO  
(b) City or town FAGUS  
(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 2

3. (a) PRINT FULL NAME FRANCES JUNE HOSEA

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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased SEPT 29 1940  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation 0

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

MOTHER FATHER { 12. Name CLAYTON HOSEA /

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

14. Maiden name MARTHA DOTY

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

16. (a) Informant's own signature \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) BURIAL (b) Date thereof 11-18-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW HOME (POLLARD)

18. (a) Signature of funeral director Clayton HoSEA

(b) Address Raytown, MO

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BUTLER  
(c) City or town FAGUS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 18  
year 1940 hour 12 M minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 11-7-1940  
11-18, 1940 to 11-18, 1940  
that I last saw her alive on 11-5, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to carditis

Due to malnutrition

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? Hayden Butler MO  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? g.c.

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

23. Signature J.P. Miller (M. D. or other) \_\_\_\_\_  
Address Pollard Ark Date signed 11-26-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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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.....  
....., 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.**

FILED FEB 17 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38268

Registration District No. 95

Primary Registration District No. 5137

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Gillis Bluff 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..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Frances Jane Hosen

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased Sept 29 1900  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 19 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name Clayton Hosen

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

14. Maiden name Martha Doty

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

16. (a) Informant.....

(b) Address.....

17. (a) Burial (b) Date thereof 11-18-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation new Hope

18. (a) Signature of funeral director Lloyd Russell

(b) Address Piggatt Ark.

19. (a) 2/8/41 (b) Kate Lutz  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler  
(c) City or town Fagus  
(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 11 day 18  
year..... 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 colitis

Due to milk

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?..... (a) Means of injury.....

23. Signature J O Heller (M. D. or other)

Address Pallard Ark. Date signed.....

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

DIPLI 1940

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

