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FEB 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

2131

State File No. _____

Registration District No. 137

Primary Registration District No. 4077

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Hale
(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 years, months or days)

In this community 45 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

(c) City or town Hale
(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.

3. (a) PRINT FULL NAME Millie Isabel Croco

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 1st year 1941 hour 10 minute A M.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widow

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

7. Birth date of deceased March 9 1851
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 1 1940 to Jan 1 1941 that I last saw her alive on Dec 31 1940 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>9</u>	<u>22</u>	_____ hr. _____ min.

Immediate cause of death arteriosclerosis

Duration year

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

Due to _____

Due to _____

10. Usual occupation Housewife

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

11. Industry or business _____

MOTHER FATHER { 12. Name unknown not known

13. Birthplace unknown not known
(City, town, or county) (State or foreign country)

14. Maiden name not known

15. Birthplace not known
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Velma Koch

(b) Address Hale Missouri

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) ~~Lakeside cemetery~~ (b) Date thereof Jan 2 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lakeside cemetery

(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? _____

18. (a) Signature of funeral director Frank E. Slater

(b) Address Hale Mo.

While at work? _____ (Specify type of place)

(e) Means of injury _____

19. (a) 1-2-1941 (b) WPKemp
(Date received local registrar) (Registrar's signature)

23. Signature WPKemp (M. D. or other) D

Address Hale Date signed 1-2-1941

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

RECEIVED
District Health Officer No. 8,
District File Number
7-07-6

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 *not*

Registered Apprentice No. _____

working under my personal supervision.

Signed

James E. Slater

Licensed Embalmer No.

937

P. O. Address

106 W 110

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.