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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2369

FEB 25 1941

Registration District No. 231

Primary Registration District No. 5315

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Rural Twp. Union
(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 1 yr. 6 months. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Union Twp.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME Mary Ann Pyatt

3. (b) If veteran, name war _____ 8. (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 Andrew Pyatt 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased March 5th 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation AT Home

11. Industry or business _____

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

16. (a) Informant Andrew Pyatt
(b) Address Keyville, Mo

17. (a) Burial (b) Date thereof Jan. 26th 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Leasburg, Missouri

18. (a) Signature of funeral director W. H. Hall
(b) Address Leasburg, Mo

19. (a) 2-10-41 (b) W. H. Hall
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 23rd
year 1941 hour 11 minute 30 P. 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 Acute Indigestion Duration _____

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

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? _____

23. Signature W. H. Hall (M. D. or other) _____
Address Leasburg Mo Date signed 1/23/41

RECEIVED

District Health Officer No. 5,

District File Number 241305

Date Filed

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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 *John H. Holloway*
Licensed Embalmer No. 3643
P. O. Address Cuba, 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.

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DEPARTMENT OF COMMERCE
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Registration District No. 231

Primary Registration District No. 5315

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Jesson 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 _____
In this community _____ (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME Mary Ann Pyatt

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 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
1 75 10 18 hr. min.

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

10. Usual occupation _____

MOTHER FATHER { 11. Industry or business _____

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) _____ (b) Date thereof (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

DEATH CERTIFICATION

20. DATE OF DEATH Month 1 day 23
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 Acute Indigestion
No physician seen
Due to Attendants, death sudden
Due to Probably Gastroenteritis

Other conditions (Include pregnancy within 3 months of death) 12.00?

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 L. J. Janas (M.D. or other) _____
Address Shelville Mo Date signed _____

SUPPLEMENTARY

