

Rev. 5-17-39
I 1951

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3275

Registration District No. 286

Primary Registration District No. 671

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn

(b) City or town New Boston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bethesda Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 yrs (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58

(c) City or town New Boston 0
(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.

3. (a) PRINT FULL NAME Mary Bishop

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 M

6. (b) Name of husband or wife Carl Bishop

6. (c) Age of husband or wife if alive 92 years

7. Birth date of deceased Aug 3 1878
(Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 23 If less than one day hr. _____ min. _____

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

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name George Passig

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

14. Maiden name Catherine Trader

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

16. (a) Informant's own signature ms Elizabeth Eddy

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Jan 27 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt Olivet

18. (a) Signature of funeral director James M. Laughlin

(b) Address Marceline Mo

19. (a) Jan 29 41 (b) Wesley Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26 year 1941 hour 3 minute 40 a.

21. I hereby certify that I attended the deceased from Sept, 1940, to Jan 26, 1941, that I last saw her alive on Jan 13, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma urinary bladder

Due to _____

Due to _____

Other conditions Generalized carcinoma
(include pregnancy within 3 months of death)

Major findings: Relief organs

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? _____

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

23. Signature J.P.M. Carter (M. D. or other) _____

Address Lawrence Date signed Jan 29 41

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.