ITE	COMMERCE Division of VI	tal Statistics	1
(Deal's	Bureau of the Census Reg. Diet. 923 Certificate	of Death no. 6211 4775	
ution		2. USUAL RESIDENCE (HOME) OF DECEASED: For newborn infant give residence of mother	11,3
13	(a) County Township On L	(a) State PILLS SOULE (b) County	Som
ence inty City	(b) City or Town. Car ATE A MO (If outside city or town write RURAL NEAR and give town	and 1111 (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	no.C
Φ	(c) Hospital or Institution: Name and Street Address		ive town)
ation ((d) Street No(If rural give LOCATION)	^
ent	(d) Length of stay in Hospital or Inst. (yrs., or mos., or days)	(e) If foreign born, how long in U. S. A.?	years
	In this community (yrs., or mos., or days)	3.(b)IF VETERAN, NAME WAR.	
r	3.(a) FULL NAME	3.(c) Social Security Account Number	3
r	Chas & Churman	N	
	4 Compare Page 16.(a) Single, married,	MEDICAL CERTIFICATION	
Death y Year	Widowed or divorced	20 DATE OF DEATH A.A. 1944., (Month, WRITE OUT) (Day)	atM.
	6.(b) Name of husband	21.I CERTIFY that death of durred on the date above sta	ited; that I
y Cause	or wife	attended Oceased from Jan 16	1944,
of Illness	6.(c) If alive, give ageye	to 19.5%, and	that I saw
os, Days	7.Birth date of deceased (mo., day, yr.) dan 6-194	h alive on a 16	19.
y Cause	8.Age Years Months Days If less than 1 day	Immediate cause of death	DURATION
	10hrsmin.	- Unummua	2465
y Cause	9.Birthplace Missonti	Due to	
ation	(Town, county, and state or foreign country)		
	10.Usual Occupation	Due to	
opsy	11.Industry or business	Other conditions.	
dent	12.Name GCO. Thurman	·······	
dent lapsed	13.Birthplace (City, town or county) (State or foreign country	(Include pregnancy within 3 months of death)	PHYSICIAN Please
Days	14. Name Pansy ScotT	OPERATION: Date of	underline the cause
Accident	(2) (2) (2) (3) (3) (3) (3) (3) (3) (3) (3) (3) (3	RO Of operation	to which
	15.Birthplace	Ty) Ta Of autopsy	should be ascribed
of Injury	16. (a) Informant's own signature June 192 Church	26: <u>PI.</u>	<u></u>
f Injury	(b) Address	22. If death was due to external causes, fill in the follo	·=
	17.(a) Run 9.90 d. (b) Date thereof Jon 19. Burial, cremation or removal (specify) (Month) (Day) (Ye	(a)(b) Date of	
to Occu.	(c) Place of burial or cremation	H (c) Where did injury occur?	
Attendant	Location near my town our	(City or town) (County)	• •
recondent	ES Some la alleration	public place (where?)	******
sition	18.(a) Signature O. Shoods	(e) Injured at work? (Yes or no)	.,,
	(c) License 24	(f) Means of Injury	Δ
Director	11 00 1 1 CA 16. SI	1) Hat eller	UNK
n & War	19 Signature Clifford Jaso District 90	23.(a) Signature	D. or other)
		(b) Address	76-
Sec. No.	Date received 20 /94 Filed No.	(c) Date signed	

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIANS

	AUDITIONAL SPACE FOR FURTHER STATEM	IENTS BY LICENSED EMBALMERS
T		ensed Embalmer No. 11 1 hereby certify that
,		isused Embanner No. 1 inereby coruly tha
the body	recorded on the reverse side of this certificate was embalmed	by L. E
No	or by	Registered student No.

Signed O Milwadi

Licensed Embalmer No

NOTE: The above statement MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license).

working under my personal supervision.

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS. Registration District No... Primary Registration District No. Registrar's No..... 1. PLACE OF DEATH 2. USUAL RESIDENCE OF DECEASED: (b) County..... (If outside city (c) Name of hospital or institution: (If outside city or town limits write "RURAL") PERMANENT (If not in hospital or institution, write street number or location) (d) Street No..... (d) Length of stay: In hospital or institution..... (If rural, give location) (Specify whether In this community..... years, months or days) (e) If foreign born, how left TEAL CERTIFICATION 3. (a) PRINT FULL NAME 20. DATE OF DEATH 3. (b) If veteran, 3. (c) Social Security No..... name war..... certify that I attended the deceased from..... 6. (a) Single, widowed, married 5. Color or 4. Sex divorced..... Ż nd than death occurred on the date and hour stated above. 6. (b) Name of husband or wife...... 6. (c) Age of husband, or wife, i BLACK 7. Birth date of deceased.....(Month) (Day) If less than on 8. AGE: Years Months Dave UNFADING 9. Birthplace....(City, town, or county) or foreign country) Other conditions/ 10. Usual occupation...... (Include pregnancy within 3 months of death) 11. Industry or business..... PHYSICIAN Major findings: 12. Name..... Of operations..... Underline 13. Birthplace... (City, town, or county) which death Of autopsy..... should be 14. Maiden name..... charged statistically. 15. Birthplace (City, town, or county) 22. If death was due to external causes, fill in the following: (State or foreign country) (a) Accident, suicide, or homicide (specify)..... 16. (a) Informant..... (b) Date of occurrence..... (b) Address..... (Burial, cremation, or removal) (c) Where did injury occur?..... 17. (a) (City or town) (County) (State) (Month) (Day) (Year) (d) Did injury occur in or about home, on farm, in industrial place, in public place? (c) Place: burial or cremation..... (Specify type of place) (g) Means of injury. 18. (a) Signature of funeral director..... (b) Address..... (Date received local registrar) (Registrar's signature)

