

FILED MAR 1 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8521
Do not use this space.

1. PLACE OF DEATH *Habitat York*

(a) County *Habitat York* Registration District No. *896*

(b) Township *York* Primary Registration District No. *6198 112* Registered No. *9*

(c) ~~St.~~ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *ANNA M. FROSS*

(a) Residence, No. *Marshfield 1 Mrs.* *0* (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *C. W. Fross*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 17 1885*

7. AGE YEARS *85* MONTHS *8* DAYS *14* If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as saw mill, bank, etc. *Herrings*

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *N. Y.*

FATHER 13. NAME *J. W. Chesley*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Penn.*

MOTHER 15. MAIDEN NAME *Olivia B. Williams*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Penn.*

17. INFORMANT (ADDRESS) *Grace Fross*

18. BURIAL INFORMATION OR REMOVAL PLACE *Marshfield* DATE *Jan 23 1941*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Michael Funeral Home*

20. FILED *Feb 1 1941* *Eliezer Hoffman* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 24 1941*

22. I HEREBY CERTIFY, that I attended deceased from *Jan 4 1941* to *Jan 21 1941*

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at *3:40 P.M.*

The principal cause of death and related causes of importance were as follows:

Lower pneumonia following influenza

Date of onset

Other contributory causes of importance: *131 lb*

Chr Bright disease

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) *John R. Bruce* M. D.

(Address) *Marshfield Mo*

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

RECEIVED

District Health Officer No. ()

District File Number 341-464

Date Filed MAR 14 1941

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 A. S. M. M. L. L.

Licensed Embalmer No. 1779

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.