

No. 4-15-17

17-22159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **9957**

APR 7 1941

992

Primary Registration District No.

5047

Registrar's No.

1. PLACE OF DEATH:

(a) County **Barry**
 (b) City or town **Rural (Ozark Twship)**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
R.F.D. # 2 Aurora Mo.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **Life**
 years, months or days)

3. (a) PRINT FULL NAME **Zelma Ivohn Atkisson**

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

4. Sex **Female** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Sept. 22 1901**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 6 9 hr. min.

9. Birthplace **Barry County Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Marshall V Atkisson**
 13. Birthplace **Barry County Missouri**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Henrietta Inman**
 15. Birthplace **Tenn.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **F.A. Atkisson**
 (b) Address **Aurora Mo.**
 17. (a) **Burial** (b) Date thereof **4/2/41**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Clay Hill Cemetery**

18. (a) Signature of funeral director **J.F. King**
 (b) Address **Aurora Mo.**

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**
 (c) City or town **Rural (Ozark Twship)**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Aurora Mo R.F.D. # 2**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **31**
 year **1941** hour **8** minute **30A.** M.

21. I hereby certify that I attended the deceased from **January 10, 1941, to March 29, 1941;**
 that I last saw her alive on **March 29, 1941;**
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to **Acute Myocardial Failure** Duration **1 Day**

Due to **Parkinsonian Syndrome** 20 years

Other conditions **Chronic Exacerbated** 2 years
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy **40A**
 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?
38

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

23. Signature **D. H. Smith, L. Kirby** (M. D. or other) **D. H. Smith**
 Address **16 E. Forest St** Date signed **7/24/41**

RECEIVED

District Health Officer No. 6

District File Number 441-528

Date Filed APR 4 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

Herman Surridge

Licensed Embalmer No. 3072

P. O. Address Aurora Mo

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.

Registration District No. 992

Primary Registration District No. 5047

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Osborne, T.O.
(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 _____ years, months or days)

3. (a) PRINT
FULL NAME

Zelma Evelyn Atkinson

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 S

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

7. Birth date of deceased (Month) (Day)

8. AGE: Years Months Days If less than one day min.
39 6 9

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

10. Usual occupation _____

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) June 7-41 (b) Don Brechbühler
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 31
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Dr. Kenneth L. Peterson (M.D. or other)

Address Aurora Date signed _____

S-9947 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.....

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, fact should be so stated above.