

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

19323  
State File No. \_\_\_\_\_  
Registrar's No. 8

Registration District No. 897

Primary Registration District No. 4543

1. PLACE OF DEATH:

(a) County Webster  
(b) City or town Seymour, mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(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

IRVING J. MASHBURN

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

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Linda Mashburn  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased march 12 - 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
87 1 27 hr. \_\_\_\_\_ min.

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

10. Usual occupation Retail merchant

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Golda Mashburn  
13. Birthplace Wisconsin  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Josephine  
15. Birthplace Wisconsin  
(City, town, or county) (State or foreign country)

16. (a) Informant Paul Berning

(b) Address 2400 E. 15th St. m

17. (a) burial (b) Date thereof 5-9-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seymour Masonic Cem.

18. (a) Signature of funeral director H. K. Kelley

(b) Address Seymour, mo

19. (a) 5-8-41 (b) P. E. Memahan  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster  
(c) City or town Seymour, mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month may day 7th  
year 1941 hour 2:45 minute 4 M.

21. I hereby certify that I attended the deceased from 5-7-41  
\_\_\_\_\_ 19\_\_\_\_ to 5-7 1941;

that I last saw her alive on 4-4 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death coma Duration \_\_\_\_\_

Due to Uremia

Due to Senility

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?  
803

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

23. Signature E. J. Beers (M. D. or other) MD

Address Seymour, mo Date signed 5-8-41

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

122  
RECEIVED

District Health Officer No. 6,

District File

641-859  
JUN 5 1941

Date Filed

MAR 16 1949

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

*H K Kelley*

Licensed Embalmer No.

*3334*

P. O. Address

*Seymour, N.H.*

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.

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STANDARD CERTIFICATE OF DEATH

State File No. 19323

Registration District No. 897

Primary Registration District No. 4543

Registrar's No.

1. PLACE OF DEATH

(a) County Webster  
(b) City or town Keyman  
(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)

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

3. (a) PRINT FULL NAME Irving J. Mashburn  
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex m 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 87 Months 1 Days 27 If less than one day hr. min.

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 (City, town, or county) (State or foreign country)  
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) (Place: burial or cremation)

18. (a) Signature of funeral director (b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 7 year 1941 hour minute M.  
21. I hereby certify that I attended the deceased from 19 to 19 that last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death uremia

Due to senility Duration  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1628  
Of autopsy  
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 (M. D. or other) Address Date signed

SUPPLEMENTARY

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

MOTHER FATHER

19323