

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

19497
State File No. ~~1234~~

Registration District No. 69 Primary Registration District No. 5108 Registrar's No. 52

1. PLACE OF DEATH:
 (a) County Dallas
 (b) City or town Rural Wayne
(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 Lifetime _____
years, months or days)

3. (a) PRINT FULL NAME PHIBE LURANIA S. JSM
 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 do
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb. 13 1969
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 11 16 hr. min.

9. Birthplace Bollinger Co. Mo. O
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business
 MOTHER FATHER
 12. Name John S. Dennis
 13. Birthplace Waynesville Mo. O
(City, town, or county) (State or foreign country)
 14. Maiden name Martha A. Jackson
 15. Birthplace Bollinger Co. Mo. O
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Oscar Loff
 (b) Address 212 S. 1st St. St. Louis, Mo.
 17. (a) Buried (b) Date thereof 1-30-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brush Creek Cem.
 18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) 6/2/194 (b) Mrs. Jake R. Berry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Bollinger
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Wayne township
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29
 year 1941 hour 6:00 minute 17. M.

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

Immediate cause of death Coronary Occlusion
 Due to _____
 Due to _____

Other conditions Infirmities of age
(Include pregnancy within 7 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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

23. Signature J. E. Graham Coroner
(M.D. or other)
 Address Lutesville, Mo. Date signed 1-29-41

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically

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

Ref. 5-17-39
 U.S. GPO: 1939 O-108511

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.

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.

Registration District No. 69 Primary Registration District No. 5108 Registrar's No.

1. PLACE OF DEATH:
(a) County Bollinger
(b) City or town Wagner, Mo.
(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 Phebe Lurania Deism
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 11 16 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 _____

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) 7/22-41 (b) Mrs. John B. Gray
(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 1 day 29
year 1949 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ 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 T. E. Graham (M. D. or other) _____
Address Lutesville, Mo. Date signed _____

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

SUPPLEMENTARY

19497