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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22107

Registration District No. 508

Primary Registration District No. 5674

State File No. _____

Registrar's No. 93

1. PLACE OF DEATH:

(a) County District

(b) City or town Rural Chillicothe Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Burial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community Wife
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County District

(c) City or town Rural - Chillicothe Twp
(If outside city or town limits, write "RURAL")

(d) Street No. District (If rural, give location) _____

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Infant child

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15
year 1941 hour 11 minute 45 M.

4. Sex Male 5. Color or race White

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 June 15 - 1941
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-15-1941
_____ 19____, to 6-15 1941;
that I last saw him alive on 6-15-1941 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days _____
Eight hours less than one day _____ hr. _____ min.

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

Immediate cause of death Morbus Caeruleus

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation _____

11. Industry or business _____

12. Name Illegitimate child

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

14. Maiden name Ethel M. Lamb

15. Birthplace District Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Callie N. Lamb

(b) Address Chillicothe Mo

17. (a) Burial (b) Date thereof 6-16-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gransfield Cem

18. (a) Signature of funeral director Jamie D. Osborn

(b) Address Chillicothe Mo

19. (a) 6-16-41 (b) H. M. Phace M.D.
(Date received local registrar) (Registrar's signature)

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? _____

Which at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Callie N. Lamb (M. D. or other) _____

Address Chillicothe Mo Date signed 6-16-1941

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.