

FILED JUL 14 1941

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

22858

Do not use this space.

1. OF DEATH
- (a) County Scotland Registration District No. 809
- (b) Township Harrison Primary Registration District No. 6034 Registered No. 0
- (c) ~~City~~ or ~~City~~ (d) Street No. 0 St. 0
- (If death occurred in Hospital or Institution, write its name instead of street and number)
- (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 Eva Saphronia Fertig 0
- (a) Residence, No. 0 St. 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 <u>Female</u> | 4. COLOR OR RACE <u>White</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Walby J. Fertig</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 27, 1883</u> | | |
| 7. AGE | YEARS <u>57</u> | MONTHS <u>5</u> |
| | DAYS <u>16</u> | 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. | |
| | 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) <u>Fair County</u> | | |
| FATHER | 13. NAME <u>Gilas Gajers</u> | |
| | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>W. Virginia</u> | |
| MOTHER | 15. MAIDEN NAME <u>Golden</u> | |
| | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>W. Virginia</u> | |
| 17. INFORMANT <u>Walby J. Fertig</u> (ADDRESS) <u>Putlidge Mo</u> | | |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Henry Lane</u> DATE <u>June 11, 1941</u> | | |
| 19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Putlidge Mo</u> <u>Putlidge Co</u> | | |
| 20. FILED <u>June 18, 1941</u> <u>W. O. Shacklett</u> Local Registrar | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/8, 1941

22. I HEREBY CERTIFY, That I attended deceased from 6/1, 1941, to 6/8, 1941.
I last saw h.e.r. alive on 6/8, 1941. Death is said to have occurred on the date stated above, at 3:30 p.m.
The principal cause of death and related causes of importance were as follows:
Tuberculosis of Lungs

Date of onset ?

Other contributory causes of importance: 12/10

Name of operation _____ Date of _____

What test confirmed diagnosis Autopsy Was there an autopsy? NO

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? NO
If so, specify _____
(Signed) E. J. Dennis, M. D.
(Address) Putlidge Mo.

RECEIVED

District Health Officer No. 10

District File Number 7-41-1222

Date Filed JUL 10 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.....

James A. Bailey....., Registered Apprentice No. 278
working under my personal supervision.

Signed J. A. Bailey
Licensed Embalmer No. 30145
P. O. Address Rutledge

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22858

Registration District No. 809

Primary Registration District No. 6054

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scotland
(b) City or town _____
(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 Eva I. Fertig
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 on
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 _____ 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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Aug 23 1941 (b) Ma R E Shalket
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scotland
(c) City or town Rural
(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 June day 8
year _____ hour _____ minute _____ 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 _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-22858