

FILLED JUL 11 1941

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

22946

Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. 868
 (b) Township Shppard Primary Registration District No. 6149
 (c) City Humble (d) Street No. 1
 (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.

Registered No. 903

2. PRINT FULL NAME

Rose Ann Merritt
 (a) Residence, No. _____ St. (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Merritt
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 16 1866
 7. AGE YEARS 75 MONTHS 4 DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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 55

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St James MO

FATHER 13. NAME Andrew Sheppard

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME Kate Taylor

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St James MO

17. INFORMANT (ADDRESS) Mrs Rose Waller Chandler Okla.

18. BURIAL, CREMATION OR REMOVAL PLACE Wishon Exp DATE 6-16-41

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith Ferguson

20. FILED 6/14 1941 W. Reed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 14 1941

22. I HEREBY CERTIFY, that I attended deceased from May 16 1941 to June 14 1941

I last saw him alive on June 10 1941. Death is said to have occurred on the date stated above, at 8:00 A.M.

The principal cause of death and related causes of importance were as follows:

Chronic Nephritis
(Coronary thromboses)

Date of onset

Other contributory causes of importance: 131h

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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

so, specify _____

(Signed) W. Reed, M. D.

(Address) _____

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 *Hubert C. Ferguson*

Licensed Embalmer No. *3945*

P. O. Address *Licking, Mo*

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. 22946

Registration District No. 868

Primary Registration District No. 6149

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Kimble
(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 Mo. (b) County Texas
(c) City or town Small Street
(If outside city or town limits, write "RURAL")
(d) Street No. near Kimble
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Rose A. Merritt

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 m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan 16, 1866
(Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days 18
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6/14 9 10/16/44 (b) J. J. Reed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from _____ 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

acting mo

SUPPLEMENTARY

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