S. No. 2
—11-10-39
. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 9 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22976

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 198

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

1. PLACE OF DEATH:

(a) County Vernon

(b) ~~City or town~~ Washington Township

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No 3 Nevada, Mo

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs 4 mos 20 dys (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Polk TD 8

(c) City or town Humansville 0

(If outside city or town limits, write "RURAL")

(d) Street No. Nat Known 0

(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME WILLIAM THOMAS MASHBURN

3. (b) If veteran, name war Nat Known

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs ORA I. L. Mashburn

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

7. Birth date of deceased Dec (Month) 20th (Day) 1873 (Year)

8. AGE: Years 67 Months 6 Days 6 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Thomas C. Mashburn
13. Birthplace (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Sarah E Hodge
15. Birthplace (City, town, or county) Mo (State or foreign country)

16. (a) Informant State Hospital No 3 Records

(b) Address Nevada Mo

17. (a) Humansville (Burial, ~~cremation, or removal~~) (b) Date thereof 6-29-41 (Month) (Day) (Year)

(c) Place: burial or cremation Humansville Mo.

18. (a) Signature of funeral director Joseph F. Fuentes

(b) Address Humansville Mo

19. (a) 6-27-41 (Date received local registrar) (b) Allen V. Hays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27th year 1941 4 hour 47 minute P. M.

21. I hereby certify that I attended the deceased from June 15th, 1941, to June 27th, 1941; that I last saw him alive on June 27th, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions Cerebral arterio Sclerosis (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy No

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature G. S. Waraich (M. D. ~~or other~~) 0

Address State Hospital No 3 Nevada Mo Date signed 6/27/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 7-41-1087
Date Filed 7-7-41

APR 17 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 C. G. Hathaway, Registered Apprentice No. 269 working under my personal supervision.

Signed Paul Finstone

Licensed Embalmer No. 3990

P. O. Address Collins, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.