

No. 2
4-13-40
5-17-39
I X23

REC'D AUG 9 1941 951

Registration District No. Primary Registration District No. 5037B

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

1. PLACE OF DEATH:

(a) County Redwood

(b) City or town Centralia Wilson Twp.
(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 NAMES SALLY ISOLINA NORHEIT

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 Single

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

7. Birth date of deceased July 20 1864
(Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation House keeper

11. Industry or business _____

12. Name Mellie M. Norheitt

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

14. Maiden name MEZIAN BOARDMAN

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

16. (a) Informant M. L. Norheitt

(b) Address Centralia Mo.

17. (a) Burial (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Centralia Mo

18. (a) Signature of funeral director J. M. McQuinn

(b) Address Centralia Mo

19. (a) 7/22-1941 (b) S. M. Mowley (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain ⁰⁰⁴

(c) City or town Centralia Rural ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. #3 (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 - 1941
year 1941 hour 5 minute 12 AM

21. I hereby certify that I attended the deceased from June 5 1941, to July 21 1941; that I last saw her alive on July 20 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension _____ years

Due to _____

Other conditions Chronic Nephritis, Cystitis
(Include pregnancy within 3 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? _____

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

23. Signature S. B. Besterman (M. D. or other) D.O.
Address Centralia Mo. Date signed 7/21/41

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 8-41-1415

Date Filed AUG 6 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 M. J. McH...

Licensed Embalmer No. 2589

P. O. Address Centralia 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, fact should be so stated above.

STANDARD CERTIFICATE OF DEATH

State File No. 24388

Registration District No. 951

Primary Registration District No. 5037B

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Audrain
(b) City or town Rural Wilson Sup
(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
In this community years, months or days (Specify whether)

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

3. (a) PRINT FULL NAME Sally L. Northcutt
3. (b) If veteran, name war 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July, day 2, year 1941, hour 11, minute M.
21. I hereby certify that I attended the deceased from 9 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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day 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)

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

16. (a) Informant (b) Address

17. (a) Burial, cremation, or removal (b) Date thereof 7/29/41 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) Date received local registrar (b) Registrar's signature E. M. Mosley

Other conditions (Include pregnancy within 3 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?

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

