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X21492

FILED AUG 8 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. **24651**

Registration District No. **8990**

Primary Registration District No. **512-5134A**

Registrar's No. **282**

**1. PLACE OF DEATH:**

(a) County Butler

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

(c) Name of hospital or institution:  
FISK ROUTE #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community Life 1 (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Flossie Elizabeth Mayberry

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 495-18-6400

4. Sex female 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 NOV. 21 1921  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>19</u>	<u>7</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation House keeping

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name S. H. Mayberry

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

14. Maiden name Orla Bays

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

16. (a) Informant Clyde Dunahoo

(b) Address Fisk Mo. D.

17. (a) Burial (b) Date thereof July 20 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ash Hill

18. (a) Signature of funeral director Min Croy

(b) Address Boylan Bluff

19. (a) 7/20/41 (b) Kate Sutz  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Butler <sup>012</sup>

(c) City or town Rural <sup>0</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 5 1/2 mile E of Fisk  
(If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 19 year 1941 hour 10 minute 0 A. M.

21. I hereby certify that I attended the deceased from on July 19 1941 to July 19 1941; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy

Due to Hemorrhage of brain

Due to \_\_\_\_\_

Other conditions 82 in  
(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 R. F. Farpley **(M. D. or other)** D  
Address Fisk Date signed July 19 1941

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

AUG 16 1941

RECEIVED

District Health Officer No.

District File Number 841-99

Date Filed 8-6-41

**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.....

*Not Embalmed*

**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.