

No. 2
1-10-41
-17-
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24884

State File No.

AUG 7 1941 208

Primary Registration District No. 5288

Registrar's No. 7

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

I. PLACE OF DEATH:

(a) County Clinton Co. Mo.
(b) City or town Rural Nardin, Tenn.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Highway 169
(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 MARY EFFIE FOUGH
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Delbert 6. (c) Age of husband or wife if alive _____ years
Marion Fough
7. Birth date of deceased Feb. 25 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 4 20 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Luther D. Childress
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Mary Elizabeth Sharp
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Norman H. Childress
(b) Address 4531 Main St K.C. Mo

17. (a) _____ (b) Date thereof July 17 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park K.C. Mo

18. (a) Signature of funeral director A. J. Sullivan

(b) Address Govt Bldg Mo.

19. (a) July 16 1941 (b) Sela Shackelford
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1941 hour 4:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____
noon 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 Continued strain Duration _____
Internal injuries
fracture of femur
Due to Auto accident

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations None

Of autopsy None

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) Accident
(b) Date of occurrence July 15 41
(c) Where did injury occur Clinton Co Mo Highway
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, or industrial place, in public place?
State highway

While at work? No (Specify type of place) (e) Means of injury Auto

23. Signature W. B. Stalling
Address Plattburg Mo Date July 15 41

AUG 12 1941

AUG 13 1941

AUG 14 1941

1702
98

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

H. A. Sullivan

Licensed Embalmer No.

1738

P. O. Address

Lower 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. _____

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 4

1. PLACE OF DEATH:

(a) County Clinton

(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 Mary E. Fouch

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: _____
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>			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)

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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

20. DATE OF DEATH: Month July day 15 - 41
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: Continous cont. injuries - fracture of femur -

Due to _____

Due to _____

Other causes of death: _____
(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) Accid.

(b) Date of occurrence 7-15-41

(c) Where did injury occur? Clinton Co. Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
State Highway

While at work? no (Specify type of place) _____
(e) Means of injury into collision with back of truck

23. Signature [Signature] (Physician)
Address Plattburg Mo Date signed _____

SUPPLEMENTAL

MOTHER FATHER

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

OCT 3 0 1947

S-24884