

No. 2
-13-40
-17-39
X23159

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29142

FILED SEP 16 1941

State File No. _____

Registration District No. 724

Primary Registration District No. 5955

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Putnam

(b) City or town RURAL YORK 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Putnam

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

(d) Street No. Lawersville Mo. 0
(If rural, give location)

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

3. (a) PRINT FULL NAME MARYALICE FORDYCE

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4
year 1941 hour 12:05 minute _____ p. _____ M.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife WEL FORDYCE

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

7. Birth date of deceased May 24 1857
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 29, 1941, to July 29, 1941; that I last saw her alive on July 29th, 1941; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>2</u>	<u>10</u>	hr. _____ min. _____

Immediate cause of death Acute recurring endocarditis, superimposed on a Valvular heart disease chronic

Due to mitral and aortic regurgitation, resulting in decompensation;

Due to massive pulmonary edema and exhaustion.

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

10. Usual occupation Home work

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

MOTHER FATHER

11. Industry or business _____

12. Name LeRoy Marshall

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

14. Maiden name Nancy Conwright

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations None

Of autopsy None

16. (a) Informant M. F. Fordyce

(b) Address Lawersville Mo.

17. (a) Burial (b) Date thereof Aug. 5-71
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wysocka Cem.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(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? _____

18. (a) Signature of funeral director J. B. Dushet

(b) Address Lawersville Mo.

19. (a) Aug 4 1941 (b) M. D. Pollock
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____

While at work? _____ (c) Means of injury _____

23. Signature D. B. Bristow (M. D. or other) M.D.
Address Bristow Bldg. Princeton Date signed 8/6/41

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

229

417

RECEIVED

District Health Officer No. 10

District File Number 9-41-1623

Date Filed SEP - 8 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 *J. O. Husted*

Licensed Embalmer No. 2978

P. O. Address Unionville

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.