

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31140**

Registration District No. **89**

Primary Registration District No. **5131**

Registrar's No. **275**

1. PLACE OF DEATH:  
 (a) County **Butler**  
 (b) City or town **Harrison**  
 (c) Name of hospital or institution: **R.F.D. #1**  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Butler**  
 (c) City or town **R.F.D. #1 Harrison**  
 (d) Street No. \_\_\_\_\_  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME **Martha Malone Fouts**  
 3. (b) If veteran, name war **no**  
 3. (c) Social Security No. **no**  
 4. Sex **F** 5. Color or race **w**  
 6. (a) Single, widowed, married, divorced **widowed**  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Oct. 23, 1855**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Sept.** day **13**  
 year **1941** hour **19:30** minute \_\_\_\_\_ P. M.  
 21. I hereby certify that I attended the deceased from **July 10, 1941** to **Sept 13, 1941**  
 that I last saw her alive on **Sept 13, 1941**  
 and that death occurred on the date and hour stated above.

8. AGE: Years **85** Months **10** Days **20** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **myocardial infarction**  
 Due to **hypertension & arteriosclerosis**  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) **gad**

9. Birthplace **Wilmington, Indiana**  
 10. Usual occupation **housewife**  
 11. Industry or business \_\_\_\_\_  
 12. Name **Unknown**  
 13. Birthplace **Unknown**  
 14. Maiden name **Mary Beek**  
 15. Birthplace **Unknown**

Major findings: Of operations \_\_\_\_\_  
 Of autopsy **none**  
 Underline the cause to which death should be charged statistically

16. (a) Informant's own signature **Mrs. E.T. Warrington**  
 (b) Address **11-1 Harrison, Mo.**  
 17. (a) **Burial** (b) Date thereof **9-**  
 (c) Place: burial or cremation **Kinsia Cem. Harrison**  
 18. (a) Signature of funeral director **Black's Mortuary**  
 (b) Address **Harrison Ark.**  
 19. (a) **10-3-41** (b) **Belle Kinnel**

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? \_\_\_\_\_  
 (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 **St. Paul** (M. D. or other) \_\_\_\_\_  
 Address **Warrington** Date signed **9/14/41**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Office No. 2,

District File Number 1041-1393

Date Filed 10/8/41

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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 Leslie D. Russell

Licensed Embalmer No. 3855

P. O. Address Corning, Ark.

**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.**

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 31140

Registration District No. 89

Primary Registration District No. 5131

Registrar's No. 374-375

1. PLACE OF DEATH:

(a) County.....  
(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.....  
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) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Martha Malme Pouts

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

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.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof Sept 15, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director Black's Mortuary

(b) Address Corning Ark

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13  
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., 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.....

Due to.....

Due to.....

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.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1941

5-31140