

JAN 13 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41273

State File No. \_\_\_\_\_

Registration District No. 21

Primary Registration District No. 4013

Registrar's No. \_\_\_\_\_

300

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

1. PLACE OF DEATH:

(a) County Atchison

(b) City or town Watson Mo.  
(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 35 yr.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Atchison

(c) City or town Watson  
(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 Maryann Comingore

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec., day 31, year 1941, hour Nine minute 30 A. M.

21. I hereby certify that I attended the deceased from Sept 15-41, 1941, to Dec 31-41, 1941, that I last saw her alive on Sept 15, 1941, and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Dan Comingore 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 5 18 41  
(Month) (Day) (Year)

Immediate cause of death Senile decay.

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

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

Other conditions (Include pregnancy within 3 months of death) 162 lb

8. AGE:	Years	Months	Days	If less than one day
	<u>100</u>	<u>3</u>	<u>26</u>	_____ hr. _____ min.

9. Birthplace Allen Town Penn  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER {

12. Name Sammual Geidner

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

14. Maiden name Marian, Freebie

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

Major findings: Of operations \_\_\_\_\_

Of autopsy none

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Helen Collins

(b) Address Watson Mo.

17. (a) Burial (b) Date thereof Jan 2  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Watson

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

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(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 Chas. E. Jones

(b) Address Watson

19. (a) 12-31-41 (b) J. A. Gray  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature J. A. Gray (M. D. or other) NO

Address Watson Date signed 12-31-41

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.....

Oral C. Johnson....., Registered Apprentice No. ~~2541~~ 2839,  
working under my personal supervision.

Signed Oral C. Johnson.....

Licensed Embalmer No. 2839.....

P. O. Address Hamburg Iowa.....

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.