

FILED FEB 27 1942

Registration District No. _____ Primary Registration District No. **9230**

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

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Marion Lewis
(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 Missouri (b) County Polk

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

(d) Street No. Marion
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME MATILDA ANNIS FINK

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27th year 1942 hour 8 minute _____ M.

21. I hereby certify that I attended the deceased from 1937 to Jan 27, 1942
that I last saw her alive on Jan 27, 1942
and that death occurred on the date and hour stated above.

4. Sex female race White

5. Color or race _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years _____ months _____ days

7. Birth date of deceased November 20, 1864
(Month) (Day) (Year)

Immediate cause of death Uremia ✓ Duration _____

Due to _____

Due to _____

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>2</u>	<u>7</u>	_____ hr. _____ min.

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

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

10. Usual occupation house wife

11. Industry or business _____

MOTHER FATHER

12. Name Martin Mosier ✓

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

14. Maiden name Martha Thomas

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

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mae Bobishy

(b) Address Bolivar

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31-42 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

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? _____

18. (a) Signature of funeral director Luteson & Co.

(b) Address Bolivar, Missouri

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

While at work _____ (Specify type of place) (c) Means of injury _____

23. Signature M. A. Jumbard (M. D. or other)

Address Bolivar, Mo. Date signed 1-29-42

RECEIVED

District Health Officer No. 7,

District File Number 2-42-146

Date Filed 2-16-42

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

A. B. Hutchinson

Licensed Embalmer No.

1331

P. O. Address

Bolivar

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3230**
Registrar's No.

Registration District No. **701**

Primary Registration District No. **5930**

1. PLACE OF DEATH:

- (a) County **Polk**
- (b) City or town **Rural**
(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 years, months or days)

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.....

3. (a) PRINT FULL NAME

Matilda A. Fink

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

3. (c) Social Security No.....

4. Sex **F**

7

5. Color or race **W**

W

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

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

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

7. Birth date of deceased.....

Nov.
(Month)

20
(Day)

1917
(Year)

8. AGE:

Years **77**

Months **2**

Days

If less than one day 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.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a).....

(Burial, cremation, or removal)

(b) Date thereof.....

(Month) (Day) (Year)

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

18. (a) Signature of funeral director.....

(b) Address.....

19. (a).....

(Date received local registrar)

(b).....

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** Day **7**
year **1942** hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
that I last saw him..... alive on.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Uremia

Due to.....

Due to.....

Chronic Interstitial Nephritis.

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

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

F
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..... (M. D. or other)
Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

