

No. 2,
1-4-41
17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7502

State File No. _____

FILED MAR 16 1942
6168

Primary Registration District No. 3032

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Bathwell Hosp. Co.
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pettis

(c) City or town Sedalia Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 1901 So Orange
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ELLA STITH TRIPLET

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3 year 1942 hour _____ minute 88 M.

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

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

7. Birth date of deceased June 28 1868
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 6 1942 to FEB. 3 1942
that I last saw him alive on 2-3-42 and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 7 Days 5 If less than one day _____ hr. _____ min.

Immediate cause of death: Circulatory failure with
Valvular Abnormalities
Ab. Valves of Heart, Aortic
Due to Ch. Inf. of Heart
with Hypertension

9. Birthplace Hardin Co. 1 Ky
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

Other conditions: Thyroid mass in
Upper Abdomen - Melanoma

Major findings: None

MOTHER FATHER

11. Industry or business _____

12. Name Samuel Stith

13. Birthplace Hardin Co. 1 Ky
(City, town, or county) (State or foreign country)

14. Maiden name Adeliza Prister

15. Birthplace Hardin Co 1 Ky
(City, town or county) (State or foreign country)

Of autopsy None

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs L. G. Griswald

(b) Address Sedalia Mo.

17. (a) Burial (b) Date thereof 2/6/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Willemerie Fun. Home

(b) Address Sedalia Mo.

19. (a) 2-6-42 (b) Mrs Anna Berger
(Date received local registrar) (Registrar's signature)

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 Harold B. Gray D. or other _____
Address Depue Mo. Date signed 2/6/42

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Sanitary Health Officer No. 8,

Serial File Number.....

Certs Filed 3-12-42

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..... *L. E. Bauldin*.....

Licensed Embalmer No. 3867.....

P. O. Address..... *Seebach*.....

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.

Registration District No. **668**

Primary Registration District No. **3032**

Registrar's No.

1. PLACE OF DEATH

(a) County **Pettis**
(b) City or town **Sedalia**
(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 **Ella S. Triplet**

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. **W**

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

7. Birth date of deceased. **June 28**
(Month) (Day) (Year)

8. AGE: Years **73** Months **7** Days **11**
(If less than one day min.)

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

10. Usual occupation

11. Industry of 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)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **19** year **1942** hour **11** minute **30** M.

21. I hereby certify that I attended the deceased from **1942** to **1942**, 19....
that I last saw him alive on **1942**, 19....
and that death occurred on the date and hour stated above.
Immediate cause of death **transverse colon**
near junction with descending colon
Duration **1 1/2**

Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations **46**
Of autopsy

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)
(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 **Frank B Long** (M. D. or other) **M.D.**
Address **Sedalia Mo** Date signed **2-6-42**

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

SUPPLEMENTARY

