

141210

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

FILED MAY 20 1942

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. 89

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City

(c) Name of hospital or institution St. Mary's = St. Mary Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days  
(Specify whether in this community 4 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Osage

(c) City or town Lynn (Rural)  
(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.? 1 years.

3. (a) PRINT FULL NAME Nora Verderbregge

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 6 year 1942 hour 1:45 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from 4-4-42 to 4-6-42, 1942, that I last saw her alive on April 6 and that death occurred on the date and hour stated above.

4. Sex F 1 5. Color or race white 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased Oct 16 1880  
(Month) (Day) (Year)

Immediate cause of death Myxo Stasis  
Prussism

Duration \_\_\_\_\_

8. AGE: Years 61 Months 5 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Chronic myo. corditis  
auricular fibrillation-fibrillation  
(fibrillation)

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation Home

Major findings: Of operations 930

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

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

MOTHER FATHER { 12. Name Shepherd Cordray

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

14. Maiden name Lina Weber

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

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? \_\_\_\_\_

16. (a) Informant's own signature Alma Howard

(b) Address Lynn Mo.

17. (a) Removal (b) Date thereof May 8 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hancock cemetery

18. (a) Signature of funeral director Seaton Bennett

(b) Address Lynn Mo

19. (a) 4-6-42 (b) Thomas Fisher  
(Date received local registrar) (Registrar's signature)

23. Signature Thomas Fisher M.D.  
(M. D. or other)

Address Jefferson City Mo Date signed \_\_\_\_\_

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....

*Seaton Pewitt*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Seaton Pewitt*

Licensed Embalmer No. *2287*

P. O. Address *Linn Mo*

**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.**