

FILED MAY 5 1942

Registration District No. 218

Primary Registration District No. 3015

Registrar's No. 56

1. PLACE OF DEATH:

(a) County COOPER
(b) City or town BOONVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 years
In this community 7 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER
(c) City or town BOONVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. ST. JOSEPH'S HOSPITAL
(If rural, give location)
(e) If foreign born, how long in U. S. A.? since child 0 years.

3. (a) PRINT FULL NAME MRS ELIZABETH DECKER

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

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

6. (b) Name of husband or wife UNKNOWN 6. (c) Age of husband or wife if alive 7 years

7. Birth date of deceased SEPTEMBER 7 1847
(Month) (Day) (Year)

8. AGE: Years 94 Months 7 Days 15 If less than one day hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER { 12. Name UNKNOWN
13. Birthplace 9
(City, town, or county) (State or foreign country)
14. Maiden name ELIZABETH LOCHMILLER
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant HOSPITAL RECORDS

(b) Address BOONVILLE, MO.

17. (a) BURIAL (b) Date thereof April 25, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELDON MO

18. (e) Signature of funeral director PHILLIPS FUNERAL HOME

(b) Address ELDON, MO.

19. (a) Apr-22-42 (b) Dr. Chas. Swep.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1942 hour 5 minute 15a. M.

21. I hereby certify that I attended the deceased from June 1935 to April 22, 1942
that I last saw h. ET alive on April 21, 1942
(and that death occurred on the date and hour stated above.)

Immediate cause of death Pneumonia hypostatic Submyelary abscess, bilateral
Due to Senility 3 days

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

Major findings: Of operations None
Of autopsy None

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 0

23. Signature William (M. D. or other) M.D.
Address Boonville, Mo. Date signed 3/22/42

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

7
1
2

1000

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 5-4-42

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 _____

Louis D. Phillips Registered Apprentice No. _____
working under my personal supervision.

Signed Louis D. Phillips

Licensed Embalmer No. 3663

P. O. Address Bedon

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14131

Registration District No. 218

Primary Registration District No. 3015

Registrar's No.

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town Bonmilla
(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 _____ (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 Elizabeth Decker

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

4. Sex M 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 Sept 7 1895
(Month) (Day) (Year)

8. AGE: Years 94 Months 7 Days 15 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____ (City, town, or county) (State or foreign country)
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
_____ 19____; that I last saw him _____ live on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Septic Pneumonia
Bronchial
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.

SUPPLEMENTARY 2

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

