

FILED MAY 7 1942

Registration District No. **190**

Primary Registration District No. **6188**

1. PLACE OF DEATH:

(a) County **WAYNE**
(b) City or town **SILVA IN MISSOURI**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **1 month 18 days** (Specify whether years, months or days)
In this community **1 month 18 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **WAYNE**
(c) City or town **SILVA**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Dorles Morina MONTGOMERY**

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 **SINGLE**
6. (b) Name of husband or wife **NONE** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **FEB 7 1942**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 1 18 hr. min.

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

10. Usual occupation **INFANT**

11. Industry or business **INFANT**

MOTHER FATHER
{ 12. Name **THOMAS MONTGOMERY**
13. Birthplace **SILVA Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **OVA JONES**
15. Birthplace **GREENVILLE MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **THOMAS MONTGOMERY**
(b) Address **SILVA MISSOURI**

17. (a) **BURIAL** (b) Date thereof **MAR 26 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **NEW PROSPECT CEMETERY**

18. (a) Signature of funeral director **Hermon W. Geph**
(b) Address **Decatur Mo**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **25**
year **1942** hour **12:50** minute **P** M.

21. I hereby certify that I attended the deceased from **March 20** 1942 to **March 25** 1942
that I last saw her alive on **March 24** 1942
and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho pneumonia** Duration **5 days**

Due to **No complications**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **107** 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 **Geo F Wagner** (M. D. or other) **M.D.**
Address **Greenville, Mo** Date signed **4-25-42**

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

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 ^{not}.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Norman G. Fisher

Licensed Embalmer No. 3357

P. O. Address Bedford Mass

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.

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-41
9288

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-881

Registration District No. 890

Primary Registration District No. 6188

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wayne

(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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Dorles M. Montgomery

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 8

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

7. Birth date of deceased Feb 7 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days _____ 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 _____

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

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

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. March 28 1942 (Date received local registrar) Dorley Dennis (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 _____ Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I have seen him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

1942
S-15881