

FILED SEP 11 1942

Registration District No. 255

Primary Registration District No. 5876

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Ozark
(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. 1 month (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon
(c) City or town Winona Star Route
(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 Amelia Jane Douglass

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

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife John M. Douglass
6. (c) Age of husband or wife if alive years 1860
7. Birth date of deceased Sept. 3 (Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 25 If less than one day hr. min.

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

10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER { 12. Name Samuel Hurst
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Cecil S. Douglass
(b) Address Winona, Mo. Star Route
17. (a) Burial (b) Date thereof 12/30/41 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Falling Springs Cem.

18. (a) Signature of funeral director Thayer, Mo.
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28 year 1941 hour 9 minute 15 P.M.

21. I hereby certify that I attended the deceased from Dec. 24, 1941 to Dec. 29, 1941, to that I last saw her alive on Dec. 24, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

Due to She was in a coma when I saw her.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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) (b) Means of injury

23. Signature [Signature] (M. D. or other) [Signature] Date signed

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

75
0
0

75

0

0

0

Hilton

RECEIVED

District Health Officer No. 5,

District File Number.

942701

Date Filed

9. 20-42

CH 2.1
-MO
/ 1-13

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 27812

Registration District No. 255

Primary Registration District No. 5876

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town York
(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 Amelia Jane Douglas
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept Day 3 Year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him/her alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 Sept 3 1866
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 2 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) _____ (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) 10/1-1942 (b) Henry M. Nilsson
(Date received local registrar) (Registrar's signature)

Due to _____
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

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

MOTHER, FATHER

