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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 7 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30745

State File No. _____

Registration District No. 180

Primary Registration District No. 5673

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Rural Monroe
(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 _____ (Specify whether _____)

In this community _____ years, months or days 75 yr 1 mo 9 days

3. (a) PRINT FULL NAME MARY ELIZABETH JUSTUS

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 2 divorced widowed

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

7. Birth date of deceased June 11 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>1</u>	<u>9</u>	hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Chris Utte

13. Birthplace Germany
(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 _____ (b) Address _____

17. (a) Burial (b) Date thereof Aug 10 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paragical Home, Old Home

18. (a) Signature of funeral director Wayne McEoy (b) Address Tracy Mo

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln

(c) City or town 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.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8 year 1942 hour 4 minute 50 A. M.

21. I hereby certify that I attended the deceased from May 10 1940 to Aug 8 1942 that I last saw her alive on Aug 8 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis (Chorea)

Due to Arterial Sclerosis

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

Major findings: Of operations 93d 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? _____

(e) While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. H. Hurlbert (M. D. or other) _____
Address Old Home Date signed 8/10/42

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.....

Wayne McCoy

Licensed Embalmer No. *35816*

P. O. Address *Troy 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30740
Registrar's No. _____

Registration District No. 180

Primary Registration District No. 5673

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

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town _____
(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 Mary Elizabeth Justus
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 11 1867
(Month) (Day) (Year)

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

9. Birthplace _____ MO
(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 Wm Justus

(b) Address Old Normal Mo.

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) Aug 9-42 (b) Miss Susan Klemm
(Date registered local registrar) (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 August year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above immediate cause of death myocarditis (chronic) Duration _____

Due to arterial sclerosis

Due to _____

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

