

FILED NOV 6 1942

Registration District No. 77

Primary Registration District No. 3008

State File No.

Registrar's No. 334

1. PLACE OF DEATH:

(a) County Calloway  
 (b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution State Hospital no 1 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 47 yrs 11 mo 20 day  
(Specify whether)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Calloway  
 (c) City or town Fulton  
(If outside city or town limits, write "RURAL")  
 (d) Street No. State Hospital no 1  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME HENRITTA FREVERT

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

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

6. (b) Name of husband or wife etc 6. (c) Age of husband or wife if alive 87 1/2 years

7. Birth date of deceased etc etc 1870  
(Month) (Day) (Year)

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation housewife

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

12. Name unknown

13. Birthplace unknown 4  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant Friends STATE Hospital no 1

(b) Address Fulton mo

17. (a) burial (b) Date thereof OCT 17-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital grounds

18. (a) Signature of funeral director C. B. Thomas

(b) Address 302 Market St. Fulton mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14  
 year 1942 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from Oct 7  
 \_\_\_\_\_, 1942 to Oct 14, 1942  
 that I last saw her alive on Oct 13, 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Both Breasts Duration 3 yrs

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

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

Other conditions 50  
(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 R. Price (M. D. or other) MD  
 Address Fulton mo Date signed 10/17/42

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

17  
1  
2

1141

**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.**

STANDARD CERTIFICATE OF DEATH

State File No. 33366

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 334

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hosp #1  
(If not in hospital or institution, give 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 Henetta Everett

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 m

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

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

8. AGE: Years Months Days 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 (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 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 10-17-1942 (b) Joie Morant (c) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 first saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

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

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

