

No. 2
-5-42
-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40909**
Registrar's No. **80**

FILED JAN -8 1947

Registration District No. _____

Primary Registration District No. **4234**

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

1. PLACE OF DEATH:
 (a) County **Iron**
 (b) City or town **Ironton**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Mary's Hospital
(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 **Missouri** (b) County **Iron**
 (c) City or town **Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. **6 miles west of Belleview**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Mary Francis Trask**
 3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **fem** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Andrew Trask** 6. (c) Age of husband or wife if alive **59** years
 7. Birth date of deceased **January 12 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 **11** **11** _____ hr. _____ min.

9. Birthplace **unknown** **Missouri**
(City, town, or county) (State or foreign country)
 10. Usual occupation **at home**

11. Industry or business _____
 12. Name **Andrew Alexander**
 13. Birthplace **unknown** **Missouri**
(City, town, or county) (State or foreign country)
 14. Maiden name **Sarah Wilkenson**
 15. Birthplace **unknown** **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **S.A. Trask**
 (b) Address **Belleview Missouri**
 17. (a) **burial** (b) Date thereof **12-27-42**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Caledonia Mo.**

18. (a) Signature of funeral director **Norman White & Sons**
 (b) Address **1717 White Ironton Mo.**
 19. (a) **12-31-42** (b) **Virginia K. Miller**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Dec.** day **23rd**
 year **1947** hour **4:22** minute **2** M.
 21. I hereby certify that I attended the deceased from **Dec. 29th**
 19 **47** to **Dec. 23rd** 19 **47**
 that I last saw her alive on **Dec. 23rd** 19 **47**
 and that death occurred on the date and hour stated above.

Immediate cause of death
acute cardiac failure
chronic myocarditis??
acute myocarditis
chronic nephritis (R kidney)
 Duration **12/23/47**

Major findings:
 Of operations _____
131 R
 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. E. Harland** (M. D. or other)
 Address **Ironton, Mo.** Date signed **12/29/42**

RECEIVED

District Health Officer No. 4

District File Number 143-15-8

Date Filed 1-7-43

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 Paul J. White
Licensed Embalmer No. 3012
P. O. Address Wright, Pa.

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.