

FILED FEB 12 1943

Registration District No. **89**

Primary Registration District No. **5328**

Registrar's No. **360**

1. PLACE OF DEATH:  
(a) County **Crawford**  
(b) City or town **Wheeling "RURAL"**  
(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 yr 10 mo** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Crawford 28**  
(c) City or town **Wheeling "RURAL"** (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 **0**

3. (a) PRINT FULL NAME **AMERICA ALICE NARSH**  
3. (b) If veteran, name war **1**  
3. (c) Social Security No. **1**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan.** day **8**  
year **1943** hour **10** minute **0** M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive **18 - 1882** years (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **10** to **19**;  
that I last saw h. **w** alive on **Jan 8**, **1943**;  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Cerebral hemorrhage.** Duration

8. AGE: Years **60** Months **3** Days **20** If less than one day hr. min.  
9. Birthplace **Wheeling W. Va. 1** (City, town, or county) (State or foreign country)

Due to  
Due to  
Other conditions (Includes pregnancy within 3 months of death) **83a1**

10. Usual occupation **Housewife**  
11. Industry or business **stamping**  
12. Name **Mrs. B. Summers**  
13. Birthplace **W. Va. 1** (City, town, or county) (State or foreign country)  
14. Maiden name **Mary Patton**  
15. Birthplace **W. Va. 1** (City, town, or county) (State or foreign country)

Major findings: Of operations  
Of autopsy  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Grace O. Narsh**  
(b) Address **3716 St. Louis ave**  
17. (a) **Burial** (b) Date thereof **Jan 11 43** (Month) (Day) (Year)  
(c) Place: burial or cremation **Leasburg**  
18. (a) Signature of funeral director **Elbert Edging**  
(b) Address **Bourbon Mo.**  
19. (a) (b) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **1**  
(b) Date of occurrence **1**  
(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 **H. F. Truitt** (M. D. or other)  
Address **Leasburg Mo.** Date signed **1-10-43**

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

17-39  
X32873

RECEIVED

District Health Officer No. 5,

District File Number

243108

Date Filed

2-12-43

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.....

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. 2040

Registration District No. 89

Primary Registration District No. 5328

Registrar's No. 560

1. PLACE OF DEATH:

(a) County Crawford

(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 \_\_\_\_\_  
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 America Abile Nash

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 18  
Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_  
to \_\_\_\_\_, 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 cerebral hemorrhage

4. Sex F 5. Color of 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 15 18  
(Month) (Day) (Year)

8. AGE: Years 60 Months 3 Days 12 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) W-Va

10. Usual occupation \_\_\_\_\_

11. Industry or 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 1-10-43 (b) H. J. Irwin, Mo.  
(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 \_\_\_\_\_

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?  
\_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

