

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

2398

State File No. _____
 Registrar's No. 2

Registration District No. 141 Primary Registration District No. 3025

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

1. PLACE OF DEATH:
 (a) County Howell
 (b) City or town West Plains
 (c) Name of hospital or institution:
at residence
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 hour
 (Specify whether
 In this community 1 hour
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Howell
 (c) City or town West Plains
 (If outside city or town limit, write "RURAL")
 (d) Street No. Pony Thomas St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? X years

3. (a) PRINT FULL NAME Unnamed Infant
 3. (b) If veteran, name war. NR
 3. (c) Social Security No. X

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 21
 year 1943 hour 12 minute 30 p. M.

4. Sex Female 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife X
 6. (c) Age of husband or wife if alive X years
 7. Birth date of deceased Jan. 21, 1943
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 21,
1943 to Jan. 21, 1943
 that I last saw her alive on Jan. 21
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
1 hr. min.

Immediate cause of death Premature birth and Inanition
 Duration 1 hr
 Due to Undetermined

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

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

10. Usual occupation X
 11. Industry or business X

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

12. Name _____
 13. Birthplace _____
 (City, town, or county) (State or foreign country)

14. Maiden name Murare Oaks
 15. Birthplace Imboden Ark.
 (City, town, or county) (State or foreign country)

16. (a) Informant Lack Oaks
 (b) Address West Plains, Mo.

17. (a) Burial (b) Date thereof 1/22/43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sadie Brown Cemetery

18. (a) Signature of funeral director Ralph Thomas
 (b) Address West Plains, Mo.

19. (a) 1-22-43 (b) L. H. St. Louis
 (Date received local registrar) (Registrar's signature)

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 Art. Shorburg M.D. (M. D. or other M. D.)
 Address West Plains, Mo. Date signed 1/22/43

11-21

RECEIVED

District Health Officer No. 5,

District File Number

Date Filed

24377
2-5-78

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, above space should be left blank.