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DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

3206

BUREAU OF THE CENSUS  
ED FEB 11 1943

State File No. \_\_\_\_\_

Registration District No. 294

Primary Registration District No. 3026

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly, Mo

(c) Name of hospital or institution 826 So Ault St.  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Moberly  
(If outside city or town limits, write "RURAL")

(d) Street No. 826 So Ault st  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Miss L. O. KEAINE FOSTER

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

4. Sex F 5. Color or race Bl.

6. (a) Single, widowed, married, divorced wid.

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

7. Birth date of deceased April 22 1885  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10  
year 1943 hour 4 minute 10 P. M.

21. I hereby certify that I attended the deceased from December 12 1941 to Jan - 10 1943  
that I last saw her alive on Jan - 9 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Septic Stenosis and nephritis

Duration 14 months

Due to not known

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

Other conditions Anaemia + Acetab  
(Include pregnancy within 3 months of death)

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>9</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation House wife

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

12. Name unk

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

14. Maiden name unk

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

16. (a) Informant Edna Nichols

(b) Address 826 So Ault st

17. (a) burial (b) Date thereof 1-14-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jacksonville Mo

18. (a) Signature of funeral director J. A. Van

(b) Address 1056 So Ault St Moberly Mo

19. (a) 1-14-43 (b) Jenna Nave  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 E. H. Schroder (M. D. or other) \_\_\_\_\_

Address Moberly, Mo. Date signed 1-14-43

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

JUN 16 1949

APR 24 1951

RECEIVED

District Health Officer No. 10

District File Number 2-43-209

FEB 10 1943

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: Robert L. Carr

Licensed Embalmer No. 3190

P. O. Address Mohing, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3206  
Registrar's No. 9

Registration District No. 294

Primary Registration District No. 3056

1. PLACE OF DEATH:  
(a) County Randolph  
(b) City or town Emberly  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
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 Loreain Forest  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color of race B 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 \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 57 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) MO

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death myocardial stenosis and nephritis  
acute nephritis, cause not determined  
Due to \_\_\_\_\_

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

Other conditions anasarca & ascites  
(Include pregnancy within 5 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy 92b  
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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature E. D. Shrader (M. D. ~~\_\_\_\_\_~~)  
Address Emberly, Mo Date signed 9-3-43

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

SUPPLEMENTARY

