S. No. 2
I—5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6465

State File No.

FILED FEB 15 1943

Registration District No. 337

Primary Registration District No. 3023

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Community O Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 days (Specify whether
In this community 24 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Clair

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME Mrs. ~~W.M.~~ Myrtle Lines

3. (b) If veteran, name war No

3. (c) Social Security No. no

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife W.M. Lines

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Sept (Month) 16 (Day) 1888 (Year)

8. AGE: Years 54 Months 4 Days 9 If less than one day hr. min.

9. Birthplace Polk Co. (City, town, or county) Iowa (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name George Rooker
13. Birthplace Keokuk (City, town, or county) IOWA (State or foreign country)

MOTHER
14. Maiden name Georgia A. Tyler
15. Birthplace Columbus (City, town, or county) Alabama (State or foreign country)

16. (a) Informant
(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-43 (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Mo

18. (a) Signature of funeral director Osceola Funeral Home
(b) Address Osceola Mo

19. (a) Jan. 25, 1943 (Date received local registrar) (b) Georgia Kitchen (Registrar's signature) I.K.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25 year 1943 hour 2 minute 15 p.M.

21. I hereby certify that I attended the deceased from Dec. 31, 1942, to Jan. 25, 1943 that I last saw h. CR alive on 1-25, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia — Duration 1 week

Due to Postoperative removal of Kidney Stone on Jan 11, 1943

Due to

Other conditions 134a
(Include pregnancy within 3 months of death)

Major findings:
Of operations Removal of Kidney Stone on 1-11-43

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Eugene D. Neville (M. D. or other) MD

Address Clinton Mo Date signed 1-25-43

1069

(Licensed Embalmer's Statement on Reverse Side)

District Health Officer No. 7,

District File Number 1-43-131

Date Filed 2-8-43

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 Chas Gilbert Hathaway

Licensed Embalmer No. Osceola 4267

P. O. Address Osceola, 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.

U. S. No. 2B
10M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6465-

Registration District No. ____ Primary Registration District No. 3023 Registrar's No. ____

1. PLACE OF DEATH:

(a) County: Henry

(b) City or town: Clinton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Com. Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 6 da (Specify whether years, months or days)

In this community 2 4 yrs

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: Myldi Lines

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: Sept 16 — 1938
(Month) (Day) (Year)

8. AGE: Years 5-4 Months 4 Days ____ If less than one day ____ hr. ____ min.

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

10. Usual occupation ____

11. Industry or business ____

MOTHER FATHER

12. Name ____

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

14. Maiden name ____

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

16. (a) Informant: Mrs. Paul Gardner

(b) Address: Osceola Mo

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 Jan Day 2-
year 1943 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____ to ____, 19____; that I last saw h 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? ____ (c) Means of injury ____

23. Signature ____ (M. D. or other) ____

Address ____ Date signed ____

SUPPLEMENTARY