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

LED MAR 8 1943
Registration District No. **275**

Primary Registration District No. **3053**

Registrar's No. **19**

1. PLACE OF DEATH:
(a) County **Phelps**
(b) City or town **Rolla**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Nelle McFarland Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day - 1 hr.**
(Specify whether
In this community **Yes -**
years, months or days)

3. (a) PRINT FULL NAME **Josphy Mae Brittain**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **February 10, 1943**
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
12. Name **Mack Brittain**
13. Birthplace **Pulaski Co. Mo.** (City, town, or county) (State or foreign country)
14. Maiden name **Jrene Hallschlag**
15. Birthplace **Pulaski Co. Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Mack Brittain**
(b) Address **Osizon, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2/12/1943** (Month) (Day) (Year)
(c) Place: burial or cremation **Piggish Cemetery**

18. (a) Signature of funeral director **P. H. H. Lillie**
(b) Address **Osizon, Mo.**

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

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County **Ph**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **11** year **1943** hour **4** minute **30** P. M.
21. I hereby certify that I attended the deceased from **February 10, 1943** to **Feb. 11, 1943** that I last saw her alive on **Feb. 11, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death
Lack of calcium in bones
Due to **4th & 12th dorsal & 1st, second & third lumbar vertebrae distorted and portions missing -**

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy **1577M**

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) (Means of injury)
23. Signature **A. H. H. H. H.** (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

2/11 - H 3

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Fred W. Gilbert

Licensed Embalmer No.....

2341

P. O. Address.....

Dixon 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. 7239
Registrar's No. 19

Registration District No. 275

Primary Registration District No. 3053

1. PLACE OF DEATH: Phelps
 (a) County.....
 (b) City or town.....
 (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.....
 In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME Dorothy Mae Brittain
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years (Day) (Year)

7. Birth date of deceased Feb 10
 (Month) (Day) (Year)

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

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

10. Usual occupation.....
 11. Industry of business.....
 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) Feb 12-43 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 3 year 1943 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... 19.....
 that I last saw him..... alive on..... 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

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

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..... (M. D. or other)
 Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

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

