

No. 9-4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7311

FILED MAR 10 1943

Registration District No. 2293

Primary Registration District No. 4427

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Waynesville
(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 20 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pulaski
(c) City or town Waynesville, Mo
(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.

3. (a) PRINT FULL NAME Cora Bell Maze

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 Married

6. (b) Name of husband or wife James R. Maze 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Dec. 31, 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 2 0 hr. min.

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

10. Usual occupation House Wife

11. Industry or business

12. Name James M. Holloway

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

14. Maiden name Not known

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

16. (a) Informant Mrs. Carl Brisch
(b) Address Waynesville, Mo.

17. (a) burial (b) Date thereof Feb. 3, 43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mitchell Cem.

18. (a) Signature of funeral director J. L. Hoops & Sons
(b) Address Waynesville, Mo.

19. (a) 2-10-1943 (b) Chas McLeod
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1
year 1943 hour 7 minute 30 p.m.

21. I hereby certify that I attended the deceased from Jan 15
Jan 17 1943 to Jan 27 1943
that I first saw him alive on Jan 27 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Wound

Due to
Due to

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

Major findings:
Of operations
Of autopsy

Duration
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?

While at work? (Specify type of place) (c) Means of injury
23. Signature R.O. Dewitt (M. D. or other) NO.
Address Waynesville, Mo Date signed 2-5-43

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

MOTHER FATHER

1170

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Pulaski County Health Office

File Number 3-43-27

Date Filed 3-9-43

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.....

Paul B. Hooper

Licensed Embalmer No. 3261

P. O. Address *Waynesville, N.C.*

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. 73 11
Registrar's No. 28

Registration District No. 290

Primary Registration District No. 4427

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Waynesville
(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)

3. (a) PRINT FULL NAME Cora Bell Mage

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 _____

7. Birth date of deceased Dec 31 (Month) (Day) (Year)

8. AGE: Years 72 Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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) _____ (Date received local registrar) (b) _____ (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 2 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death uremia Duration _____

Due to Chronic Nephritis

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 _____

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

SUPPLEMENTARY

MOTHER FATHER

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

