

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. 3017

Registrar's No. 5960

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

FILED MAY 10 1943 27882

1. PLACE OF DEATH:

(a) County Cooper

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

(c) Name of hospital or institution: St. Joseph Hospital.
(If not in hospital or institution, write street number or location)

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

In this community All of life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

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

(d) Street No. 608 E. High.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Marnie Kate O'Bryan.

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

4. Sex Felame 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John O'Bryan. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 7th 1883
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>1</u>	<u>30</u>	_____hr. _____min.

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

10. Usual occupation Housewife.

11. Industry or business At Home.

12. Name Unknown.

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

14. Maiden name Unknown.

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

16. (a) Informant Miss Julia Davis.

(b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof April 29th 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove Cem.

18. (a) Signature of funeral director Goodman Tholler
(Specify type of place) (b) Address Boonville, Mo.

19. (a) April-27-43 (b) Dr. Chas. Swap
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27th year 1943 hour 4 minute 45 a. M.

21. I hereby certify that I attended the deceased from November 10 1942 to April 26 1943; that I last saw her alive on April 26 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma (of lung). Duration 2 1/2 yrs

Due to _____

Due to _____

Other conditions degenerative myocarditis
(include pregnancy within 3 months of death) med.

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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature M. L. Decker (M. D. or other) MD

Address Boonville Mo Date signed 4/27/43

FILED

District Health Officer No. 8,

District File Number _____

Date Filed ~~4-27-43~~

5-7-43

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 G. F. Boller

Licensed Embalmer No. 3062

P. O. Address Boonville, 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.