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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15052

LED APR 28 1943

State File No.

Registration District No. 266

Primary Registration District No. 5898

Registrar's No.

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town Jara rural Richland
(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 1 hr. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ozark
(c) City or town Jara rural Richland
(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 1st
year 1943 hour 5.00 minute A.M.
21. I hereby certify that I attended the deceased from
Feb 1, 1943 to Feb 1, 1943
that I last saw h.e.r. alive on Feb 1, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death
Congenital Deformity

Due to unknown
Due to

Other conditions General Weakness
(Include pregnancy within 3 months of death)
Breathing weak + irregular

Major findings:
Of operations
Of autopsy

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

3. (a) PRINT FULL NAME Scharlene Bird

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 single

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

7. Birth date of deceased Feb 1 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 1 hr. min.

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

10. Usual occupation None

11. Industry or business none

MOTHER FATHER { 12. Name Champ Bird
13. Birthplace Ozark Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Dorwell Russell
15. Birthplace Ozark Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Champ Bird
(b) Address Jara Mo.

17. (a) Burial (b) Date thereof 2 1 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parsons
18. (a) Signature of funeral director D. P. Hightower

(b) Address Dora H. H. Hightower

19. (a) 4-1-1943 (b) D. S. Claybrook
(Date received local registrar) (Registrar's signature)

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 Mrs. H. J. Hillard (M. D. or other) Surge
Address Blanch, Mo. Date signed 3.22-43

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

RECEIVED

District Health Officer No. 6,

District File Number 442-440

Date Filed 4/27-43

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.....

Licensed Embalmer No.....

P. O. Address.....

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

(check)
State File No. 15-05-2

Registration District No. 266

Primary Registration District No. 5-898

Registrar's No.

1. PLACE OF DEATH:

(a) County Clay ark

(b) City or town Rural
(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 1 hr (Specify whether years, months or days)

3. (a) PRINT FULL NAME Scharlene Bird

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

5. Color or race _____ 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 Feb 1 - 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day _____ hr _____ 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 Mo (b) County Clay ark

(c) City or town Rural
(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 1943 year. _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ live 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 _____

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) (e) Means of injury _____

23. Signature O. J. Claybrook (M. D. or other) _____
Address Caulfield Mo Date signed _____
Local Registrar

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

SUPPLEMENTARY

MOTHER FATHER

S-15052