

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15781

State File No. \_\_\_\_\_

Registration District No. 373

Primary Registration District No. 6316

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Webster  
(b) City or town Rural - High Prairie Township  
(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 x  
In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. High Prairie Township  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country x

3. (a) PRINT FULL NAME Effie Mae Rost

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed 2

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

7. Birth date of deceased April - 14 - 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 11 28 x hr. x min.

9. Birthplace Webster County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Allen Graves

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

14. Maiden name Rachael Pierson

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

16. (a) Informant Mrs. Anna Farr

(b) Address Marshfield, Mo.

17. (a) Burial (b) Date thereof 4-13-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Teague's Cemetery

18. (a) Signature of funeral director [Signature]  
(b) Address Marshfield, Mo.

19. (a) Apr 21 1943 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12  
year 1943 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Dec. 24, 1942, to April 12, 1943  
that I last saw her alive on April 10, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis, chronic, non-infectious. Duration Unknown

Due to Arteriosclerosis and Vascular Hypertension Unknown

Due to Diabetes Mellitus Unknown

Other conditions Myocarditis, arterioscleritis Unknown  
(Include pregnancy within 3 months of death)

Major findings: Of operations 61  
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 0

23. Signature C.P. Macdonald (M. D. or other) M.D.  
Address Marshfield, Mo. Date signed 4/13/43

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

276  
22/43

920

APR 22 1963

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**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. 3312

P. O. Address Marshfield, 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.**