V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 17263

FILED MAY 18 1943

Registration District No. 3 Primary Registration District No. 5021 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Atchison
(b) City or town Watson, Nishnebotna (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 11 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Atchison
(c) City or town Watson (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 FRANCES FLORA TRITES
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 WIDOW
6. (b) Name of husband or wife Edwin Trites
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased September (Month) 10 (Day) 1860 (Year)

8. AGE: Years 82 Months 6 Days 4 If less than one day hr. min.

9. Birthplace Mendota (City, town, or county) Illinois (State or foreign country)
10. Usual occupation house wife
11. Industry or business at home
FATHER
12. Name Warren Holcomb
13. Birthplace unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah Bass
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Vivian Herren
(b) Address Watson Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 15 '43 (Month) (Day) (Year)
(c) Place: burial or cremation Moran Kansas
18. (a) Signature of funeral director Oral C. Johnson
(b) Address Hamburg Iowa
19. (a) May 15 '43 (Date received local registrar) (b) J. A. Gray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1943 hour 6 minute 55 a M.
21. I hereby certify that I attended the deceased from May 2, 1943, to May 14, 1943 that I last saw her alive on May 8, 1943 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cerebral Softening | 4 da. |
| Due to Cerebral Hemorrhage | 12 da. |
| 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M. D. ~~or other~~)
Address Hamburg Ia Date signed 5/14/43

(Licensed Embalmer's Statement on Reverse Side)

## 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 me

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

working under my personal supervision.

Signed Oral C. Johnson

Licensed Embalmer No. 2839

P. O. Address Hamburg Iowa

**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.**