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5-17-39

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 19[illegible]

Registration District No. 18

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24241

Primary Registration District No. 3002

Registrar's No. 100

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 7 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Audrain
(c) City or town Centralia RFD
(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 IDA ALICE IMAN

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 Widow

6. (b) Name of husband or wife B.L. IMAN

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

7. Birth date of deceased June (Month) 30 (Day) 1872 (Year)

8. AGE: Years 71 Months 0 Days 5 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Ben White
13. Birthplace U.N. (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Bertton
15. Birthplace U.N. (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs Louise Thelmans
(b) Address Centralia Mo R.F.D.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Centralia Mo

18. (a) Signature of funeral director M. McDonald
(b) Address Centralia Mo

19. (a) 7/6-1943 (Date received local registrar) (b) Margaret H Mackie (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5 year 1943 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 23 1943 to July 5 1943 that I last saw her alive on July 5 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion — Duration 5 hrs.

Due to .....

Due to .....

Other conditions Chronic Cardio-Renal Vascular disease.
(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 E. J. Bestmann (M.D. or other) D.O.
Address Centralia, Mo. Date signed 7/7/43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-43-1375
Date Filed AUG 11 1943

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 M J McDaniel

Licensed Embalmer No. 4313

P. O. Address Centralia Wn

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24241 a ug.

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

1. PLACE OF DEATH:

(a) County Audrain

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

(c) Name of hospital or institution: General Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 7 da.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Audrain

(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 .....

3. (a) PRINT FULL NAME Edw A. Oman

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 W

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

7. Birth date of deceased June (Month) 30 (Day) 82 (Year)

8. AGE: Years 71 Months 0 Days If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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) 10/5/43 (Date received local registrar) (b) Margaret K Mackie (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day ..... year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ....., 19.... to ....., 19....;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

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? .....
(Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

S-24241