

No. 2  
11-10-39  
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. 25101

FILED AUG 7 1943

Primary Registration District No. 5562

Registrar's No. 14

47  
0  
3  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Iron

(b) City or town Rural - Arcadia Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: The Home for Aged Baptists  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs - 10 mos 2 day  
(Specify whether years, months or days)

In this community 2 yrs 10 mos 2 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 47

(a) State Mo. (b) County Iron

(c) City or town Rural - Arcadia  
(If outside city or town limits, write "RURAL")

(d) Street No. The Home for Aged Baptists  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

8. (a) PRINT FULL NAME Minnie Doak

8. (b) If veteran,  name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7  
year 1943 hour 5 minute 40 A.M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife A. B. C. Doak

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

7. Birth date of deceased Jan. 2, 1877  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 3<sup>rd</sup> 1943 to July 7<sup>th</sup> 1943, 1943, that I last saw her alive on July 3<sup>rd</sup> 1943, and that death occurred on the date and hour stated above.

Immediate cause of death: acute Bilateral Bronchial Pneumonia

8. AGE: Years 66 Months 6 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace North Texas 1  
(City, town, or county) (State or foreign country)

Due to Hypertensive Heart??

Due to Chronic myocarditis??

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Housewife

11. Industry or business Has own home

MOTHER FATHER { 12. Name Moses Masey

13. Birthplace Montgomery Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Caldwell

15. Birthplace North Texas 1  
(City, town, or county) (State or foreign country)

Major findings: none

Of operations no

Of autopsy no

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

16. (a) Informant Mrs. H. Kearney

(b) Address Bronton, Mo.

17. (a) Burial (b) Date thereof 7-8-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arcadia Mo.

18. (a) Signature of funeral director Norman White, D.S.

(b) Address Bronton Mo.

19. (a) 7-26-43 (b) Burgess R. Miller  
(Data 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 R. E. Harland, Jr., M.D.  
Address Bronton Mo. Date signed 7/9/43

RECEIVED

District Health Officer No. 4

District File Number 843-251

Date Filed 8-6-43

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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 Paul J. White

Licensed Embalmer No. 3012

P. O. Address Boston Nev.

**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, above space should be left blank.**