

FILED AUG 13 1943

State File No. _____

Registration District No. 231

Primary Registration District No. 5806

Registrar's No. 227

1. PLACE OF BIRTH:

(a) County MONROE
 (b) City or town RURAL - So. Fork July
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
12 MI. S.E. OF PARIS
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 19 YRS. (Specify whether years, months or days)

3. (a) PRINT FULL NAME JANE BERILLA O'FALLON

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, WIDOWED
 6. (b) Name of husband or wife JOHN O'FALLON
 6. (c) Age of husband or wife if alive 7 years (Day) (Year)
 7. Birth date of deceased NOV. 7, 1869
 (Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 18
 If less than one day _____ hr. _____ min.

9. Birthplace MONROE CO., MO.
 (City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name GRANVILLE MILTON STEPHENSON
 13. Birthplace N.K. (City, town, or county) (State or foreign country)
 14. Maiden name VIRGINIA ANN TURNBOUGH
 15. Birthplace MO. (City, town, or county) (State or foreign country)

16. (a) Informant Nellie M. O'Fallon
 (b) Address PARIS, MO.

17. (a) BURIAL (b) Date thereof 7-26-43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WALNUT GROVE
 18. (a) Signature of funeral director Speed & Blakey
 (b) Address PARIS, MO.

19. (a) 7-25-43 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MONROE
 (c) City or town RURAL
 (If outside city or town limits, write "RURAL")
 (d) Street No. 12 MI. S.E. OF PARIS
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 25
 year 1943 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1-10-43
 to July 24, 1943
 that I last saw her alive on July 24, 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
 Duration 2 days

Due to Diphtheria Duration 8 days

Due to Senility

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 F. A. Barnett (M. D. or other) MO
 Address PARIS, MO. Date signed 7-25-43

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

RECEIVED

District Health Officer No. 10

District File No. **8-43/392**
AUG 1-1-1943

Date Filed

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..... *W. Blaney*

Licensed Embalmer No. *2616*

P. O. Address..... *PARIS, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *aug*

Registration District No. *227*

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Monroe*
(b) City or town *Rural So. Fork*
(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 _____
years, months or days)

3. (a) PRINT FULL NAME *Berily J. O'Fallon*

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 *Wid*

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years *73* Months _____ Days _____ (Unless than one day) _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *7-25-43* (b) *Wayne G. Gator*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year *1943* hour _____ minute *50 A.M.*

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

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

5 25261