

No. 2
-1-4-41
-17-39-
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27543
Registrar's No. 733

ED SEP 11 1943
Registration District No. 85

Primary Registration District No. 100

1. PLACE OF DEATH:
(a) County. BUCHANAN.
(b) City or town. ST. JOSEPH
(c) Name of hospital or institution: State Hospital #2
(d) Length of stay: In hospital or institution. 10 yrs. 5 mos.
In this community 10 yrs. 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn
(c) City or town Brookfield
(d) Street No. Rural Route #2
(e) Citizen of foreign country? No.

3. (a) PRINT FULL NAME Rachel Combs

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. Single

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

7. Birth date of deceased. 5 7 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>2</u>	<u>15</u>	_____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name James W. Combs
13. Birthplace Unknown Indiana
14. Maiden name Mary J. McQuerry
15. Birthplace Unknown Indiana

16. (a) Informant Lizzie Dean
(b) Address Brookfield, Missouri

17. (a) Burial (b) Date thereof Aug 22 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Homer Bowden
(b) Address Brookfield, Mo

19. (a) 8/22/43 (b) Re Hazog
(Date received local registers) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20
year 1943 hour 4:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from August 13, 1943, to August 20, 1943; that I last saw her alive on August 19, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death. Broncho pneumonia chr. myo. carditis

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 930

Major findings: _____
Of operations _____
Of autopsy _____

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 PB Sweeney (M. D. or other) MD
Address State Hosp. #2 Date signed 8-26-43

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

1233

Shunt Joseph, Mo

1001
two P
-N
A
A
T

1st
Robert
W

1884
Fr
and

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 Home Barden
Licensed Embalmer No. 3295
P. O. Address Brookfield 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.