

Registration District No. **46** Primary Registration District No. **4066** Registrar's No. _____

1. PLACE OF DEATH:

(a) County **CALDWELL**
(b) City or town **KINGSTON**
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Caldwell**
(c) City or town **Kingston**
(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 **CHARLOTTE FERNELIA BETHEL.**

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 **JULY 14 1904.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 10 29 hr. min.

9. Birthplace **KINGSTON, MISSOURI.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Invalid**

11. Industry or business _____

MOTHER FATHER
12. Name **ROBERT A. BETHEL.**
13. Birthplace **KINGSTON, MISSOURI.**
(City, town, or county) (State or foreign country)
14. Maiden name **AUTIE BRUER.**
15. Birthplace **KINGSTON, MISSOURI.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Autie Bethel**
(b) Address **Kingston Mo**
17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **76 15 1943.**
(Month) (Day) (Year)
(c) Place: burial or cremation **KINGSTON, CEMETERY.**

18. (a) Signature of funeral director **Cramer Clark**
(b) Address **KINGSTON, MISSOURI.**

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **10th**
year **1943** hour **11** minute _____ M.

21. I hereby certify that I attended the deceased from **May 17, 1943** to **June 10, 1943**
that I last saw her alive on **June 9th 1943**
and that death occurred on the date and hour stated above

Immediate cause of death **Wentle Delata-tion of the Heart** Duration **Short**

Due to **Dental Infection**
Epileptic Convulsions

Other conditions **This patient has been treated**
(Include pregnancy within 3 months of death)

Major findings: Of operations **9504**
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) (b) Means of injury
23. Signature **W.D. House** (M. D. _____)
Address **Kingston Mo** Date signed **6-11-43**

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

No. 2
5-17
X32873

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MAILED AUG 27 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 Caramer Clark

Licensed Embalmer No. 3257

P. O. Address Kingston, 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. 557
Registrar's No. _____

Registration District No. 46 Primary Registration District No. 4066

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Kingston
(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 _____ (Specify whether)
years, months or days

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 _____

3. (a) PRINT FULL NAME Charlotte F. Bethel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day _____
year 1943 hour _____ minute _____ M.
21. I hereby certify that I received the deceased from _____
that I have seen him alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 5
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Duration
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy _____

7. Birth date of deceased July 14 1866
(Month) (Day) (Year)
8. AGE: Years 38 Months 10 Days _____ Unless than one day _____ min.
9. Birthplace Mo.
(City, town, or county) (State or foreign country)

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 _____

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)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____
(b) Address _____

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

19. (a) 8/16/43 (b) Corinne Garrett
(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTARY

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

27818