S. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 10 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28377

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 86

16

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

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Christa Hogan
(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 Mo. (b) County Howell
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME Chas Terry DeMaris
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓
4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased 4-17-1943 (Month) (Day) (Year)

8. AGE: Years | Months | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace West Plains (City, town, or county) Mo (State or foreign country)
10. Usual occupation Infant
11. Industry or business .....
FATHER
12. Name Chas DeMaris
13. Birthplace Pikeston (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Grace M McClue
15. Birthplace Hawkeye (City, town, or county) Iowa (State or foreign country)
16. (a) Informant Mrs A McRae
(b) Address West Plains, Mo
17. (a) B. (Burial, cremation, or removal) (b) Date thereof 4-23-43 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Lawn
18. (a) Signature of funeral director Robert ...
(b) Address West Plains Mo
19. (a) ~~8-3-43~~ 8-3-43 (Date received local registrar) (b) 8-3-43 (Registrar's signature) Gail Harlin

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 23 year 43 hour 7 minute 00 9 M.
21. I hereby certify that I attended the deceased from April 17, 1943, to April 23, 1943; that I last saw him alive on April 23, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Nephritis	4 days
Due to Exact cause unknown	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

130

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 0

23. Signature A. H. Lonsburgh (M. D. or other)
Address West Plains, Missouri Date signed 7/16/43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 94554
Date Filed 9-8-43

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.....

Licensed Embalmer No.....

P. O. Address.....

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.