

Dr H. M. 38704

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

SEP 9 1943
Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 102

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Phillicotte
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 901 Webster 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME ALICE GERTRUDE STURTEVANT

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W. 6. (a) Single, Widow married, divorced

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

7. Birth date of deceased July - 15 - 1858
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 16 If less than one day _____ min.

9. Birthplace Linn Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Mr. Murrain

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Murrain

15. Birthplace W. Va
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Toy Lambert

(b) Address Phillicotte Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2 - 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Brookfield Mo

18. (a) Signature of funeral director Will Funeral Chapel
(Specify type of place)

(b) Address Brookfield Mo

19. (a) SEPT 2 (Date received local registrar) (b) Thos Elba Curry (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Livingston

(c) City or town Phillicotte
(If outside city or town limits, write "RURAL")

(d) Street No. 901 Webster
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31 year 1943 hour 6 minute 10 M.

21. I hereby certify that I attended the deceased from May 28, 1943, to Aug 31, 1943 that I last saw her alive on Aug 31, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic cholecystitis Duration 2 yrs.

Due to gall stones

Due to _____

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

Major findings: 126

Of operations _____

Of autopsy none

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? _____

23. Signature Jerry Lee MD (M. D. or other) _____

Address Phillicotte Mo Date signed 9-1-43

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I 41951

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..... *J. R. Blacklock*
Licensed Embalmer No. *2246*
P. O. Address *Brookfield Ms*

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.