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43
5-17-33
X-13

FILED SEP 13 1943
Registration District No. **2/15**

Primary Registration District No. **5783**

Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County Miller
(b) City or town Rural - Richmond Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Meller Co. Old Peoples Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Miller
(c) City or town Shenier
(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 MATHONIA FULKEY KINDEY
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 23rd
year 1943 hour 11 minute 30 P. M.
21. I hereby certify that I attended the deceased from June 23
1938, to August 22nd 1943;
that I last saw her alive on August 22nd 1943;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Deceased
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 14 1853
(Month) (Day) (Year)

Immediate cause of death Cerebral thrombosis Duration 4 days
Due to arteriosclerosis years?
Due to _____
Other conditions Mixed strokes years?
(Include pregnancy within 3 months of death)

8. AGE: Years 89 Months 6 Days 9 If less than one day _____ hr. _____ min.

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace Shenier Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business _____
12. Name W.M. McCubbins
13. Birthplace Shenier Mo
(City, town, or county) (State or foreign country)
14. Maiden name Susan DeGroot
15. Birthplace Camden Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Lucy M. Nance
(b) Address Lebanon Mo Hwy 5.
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-24-43
(Month) (Day) (Year)
(c) Place: burial or cremation Victory Park Cem
18. (a) Signature of funeral director R.B. Deuser
(b) Address Pickland Mo.
19. (a) Sept 4-43 (Date received local registrar) (b) Jessie Perkins (Registrar's signature)

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) (c) Means of injury _____
23. Signature W.M. A. Gould (M. D. or other) DO.
Address Shenier Mo Date signed Sept 11/43

1017

RECEIVED

Miller County Health Dep't.

County File Number 43-67

Date Filed 9-7-43

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. 3198

P. O. Address Fishland

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. 1000 SEP 13 1943

Registration District No. 2/15 Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Rural Tusculum
(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 years, months or days)

3. (a) PRINT FULL NAME Mathonia Fulley Noid

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 _____

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

7. Birth date of deceased Dec 14 1854
(Month) (Day) (Year)

8. AGE: Years 89 Months 8 Days _____ If less 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data 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 Aug Day 23 Year 1943 Hour 3:30 Minute 00 P. M.

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

MOTHER FATHER

28806