

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29058**

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

FILED SEP 2 1943

Registered District No. **22** Primary Registration District No. **5-9-13-1412** Registrar's No. **40**

1. PLACE OF DEATH: **Pike**
 (a) County **Pike**
 (b) City or town **Curryville**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **1**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **11 d** (Specify whether
 In this community **50 yrs.** (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Pike**
 (c) City or town **Curryville**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Erasmus P. Magee**
 3. (b) If veteran. **No** name war **No**
 3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Aug** day **16th**
 year **43** hour **8** minute **00 P.M.**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married. **2 divorced Widower**
 6. (b) Name of husband or wife **Laura Magee**
 6. (c) Age of husband or wife if alive **years 27 - 1858**
 7. Birth date of deceased **Jan 27 - 1858**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug 10 1943 to Aug 16 1943**
 that I last saw him alive on **Aug 15 1943**
 and that death occurred on the date and hour stated above.

8. AGE: Years **85** Months **6** Days **19**
 If less than one day hr. min.

Immediate cause of death **Myocardial Insufficiency** **24 hrs**
 Due to **arteriosclerosis** **10 yrs.**

9. Birthplace **Near Louisiana Mo. 1**
 (City, town, or county) (State or foreign country)

Other conditions **Bronchial Asthma** **15 yrs.**
 (Include pregnancy within 3 months of death)

10. Usual occupation **Retired Farmer**

MOTHER FATHER
 11. Industry or business _____
 12. Name **Joel Magee**
 13. Birthplace **D. K.** (City, town, or county) (State or foreign country)
 14. Maiden name **Fanna Williams**
 15. Birthplace **D. K. Ky 1** (City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings: **9322**
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Pansy Magee**
 (b) Address **Curryville Mo**

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) Means of injury _____

17. (a) **Burial** (b) Date thereof **Aug. 18-1943**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Mount Air**

18. (a) Signature of funeral director **H. B. Elmore**
 (b) Address **Bowling Green**

19. (a) **Aug. 28/43** (b) **Mrs Frank Hadon**
 (Date received local registrar) (Registrar's signature)

23. Signature **Glenn R. Oney** (M. D. or other) **No.**
 Address **Bowling Green, Mo.** Date signed **8-18-43**

1148

SEP 13 1943

SEP 24 1943

RECEIVED

District Health Officer No: 10

District File Number 9-43-1439

Date Filed SEP 8 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 *N. B. C. Moore*

Licensed Embalmer No. 3466

P. O. Address *Bowling Green*

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.