

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22-22

D SEP 4 1943
Registration District No. 280

Primary Registration District No. 5964

Registrar's No. 38

1. PLACE OF DEATH:
(a) County Platte
(b) City or town Parkville, Pettis Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7 miles North (Rural)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 3 year years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Platte 83
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 7 miles North
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mable DeBord
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced x 3
6. (b) Name of husband or wife Clint De Bord
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Nov 2 1875
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug, day 8
year 1943 hour 7 minute 30 P.M.
21. I hereby certify that I attended the deceased from Aug 3
1943 to Aug 3 1943
that I last saw her alive on Aug 3 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
67 9 1 hr. min.
9. Birthplace Holtton Kansas
(City, town, or county) (State or foreign country)
10. Usual occupation House Keeper

Immediate cause of death Pneumonia
Due to Hypostasis
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business Home
12. Name Jacob De Bord
13. Birthplace don't know Penna
(City, town, or county) (State or foreign country)
14. Maiden name Malinda Fisher
15. Birthplace don't know - I
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs Joseph Campbell
(b) Address RFD # 2 Parkville Mo
17. (a) Burial (b) Date thereof Aug 6 - 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Parkville Mo
18. (a) Signature of funeral director Edward Francis
(b) Address Parkville Mo
19. (a) 8-15-43 (b) Mrs Clay Liffie
(Date received local registrar) (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) (e) Means of injury _____
23. Signature D. W. Underwood (M. D. or other)
Address Parkville Mo Date signed 8/11/43

RECEIVED

District Health Officer No. Platte

District File Number 9-43-84

Date Filed 9-2-43

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 Me
....., Registered Apprentice No.
working under my personal supervision.

Signed Ieland H Francis

Licensed Embalmer No. 3451

P. O. Address Fairville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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. _____

Registration District No. 280

Primary Registration District No. 5964

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Rural Platte sup
(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

3. (a) PRINT FULL NAME

Mable De Boid

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 2

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

7. Birth date of deceased Nov (Month) 2 (Day) _____ (Year)

8. AGE: Years 67 Months 9 Days _____ (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____ (Date 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 Nov year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Suppurative Duration _____

Due to No not know

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

SUPPLEMENTARY

10911

29082