S. No. 2
1—5-42
5-17-39
P1 X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 13 1943

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 29472

Registration District No. 324 | Primary Registration District No. 3072 | Registrar's No. 154

1. PLACE OF DEATH:
(a) County: Saline
(b) City or town: Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbons Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 hours (Specify whether years, months or days)
In this community: 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Saline
(c) City or town: Marshall
(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: 0

3. (a) PRINT FULL NAME: George Mathew Washington
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Male
5. Color or race: Black
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Ethelyn
6. (c) Age of husband or wife if alive: 65 years
7. Birth date of deceased: March, 15, ~~1943~~ 1875 (Month) (Day) (Year)

8. AGE: Years 68 | Months 4 | Days 17 | If less than one day: hr. min.

9. Birthplace: Near Slater Mo (City, town, or county) 0 (State or foreign country)
10. Usual occupation: R.R. Employee- Laborer
11. Industry or business: R.R. Alton
FATHER
12. Name: Will Washington
13. Birthplace: Don't Know (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name: Don't know
15. Birthplace: Don't Know (City, town, or county) 9 (State or foreign country)
16. (a) Informant: Ethelyn Washington
(b) Address: Slater Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug, 7, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Slater Cemetery
18. (a) Signature of funeral director: Jones and Salzer
(b) Address: Slater Mo.
19. (a) Aug 5, 1943 (Date received by local registrar) (b) Mrs T.O. Westbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug, 2, 1943 day year 1943 hour 1.45 P.M. minute M.
21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Generalized Peritonitis | 24 hrs |
| Due to: Ruptured appendix | 8 days |
| Due to: Acute Appendicitis | 3 days |
| Other conditions (Include pregnancy within 3 months of death): 12111 | |

Major findings:
Of operation: Generalized peritonitis Ruptured appendix
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:
23. Signature: O.A. McDurneyMD (Physician or other)
Address: Slater Mo Date signed 8-5-43

1215

(Licensed Embalmer's Statement on Reverse Side)

NOV 29 1943

RECEIVED DEC 1 1943
District Health Officer No. 8,
District File Number 9-1073
Date Filed

**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 Herman Salzer

Licensed Embalmer No. 1831

P. O. Address Slater Missouri.

**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.**