

No. 2
9-4-41
17-39
X2948

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31989**

FILED SEP 16 1943

Registration District No. **3037**

Primary Registration District No. **3037**

Registrar's No. **150**

1. PLACE OF DEATH:

(a) County Lawrence

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

(c) Name of hospital or institution: Aurora Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0
(Specify whether years, months or days)

In this community 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

(c) City or town Aurora
(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 Sharon Kay Dass

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Infant

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

7. Birth date of deceased August 31, 1943
(Month) (Day) (Year)

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

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Alvin Ernest Dass

13. Birthplace Lawrence County, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Lois Todd

15. Birthplace Lawrence County, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Rgina Dass

(b) Address 211 Vernon Ave.

17. (a) Burial (b) Date thereof Sept 5 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zion Cem.

18. (a) Signature of funeral director Jessie J. Home

(b) Address 111 Vernon Ave.

19. (a) 9-6-43 (b) Ludy Crawley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1943 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from Aug. 31, 1943 to Sept. 2, 1943
that I last saw her alive on Sept. 2, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to _____

Due to _____

Other conditions 159
(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 R.D. Conway (M. D. or other)

Address Aurora Mo. Date signed 9/7/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1943 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 943-1082

File No. 9-14-43

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.....

P. O. Address.....

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.

Registration District No. 283 Primary Registration District No. 3007

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Lawrence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Arrow Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days (Specify whether)

3. (a) PRINT FULL NAME Sharon Kay Doss

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 S

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

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

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

9. Birthplace Mo. (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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9/6/43 (b) Cecilia Crook (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lawrence
(c) City or town C (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 Sept year 1943 hour _____ minute _____ M.

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

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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

31989