

3. No. 2
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5-17-39
X32875

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32765

REC'D OCT 11 1943

State File No.

Registration District No. 354

Primary Registration District No. 6197

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural Burdine
(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 1
(Specify whether
In this community 2 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Texas 107
(c) City or town Rural
(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. D

3. (a) PRINT FULL NAME Infant. (not named)

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

4. Sex M. 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 Sept 29 1943
(Month) (Day) (Year)

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

9. Birthplace Texas MO. IN
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name Lester Cable
13. Birthplace MO
(City, town, or county) (State or foreign country)
14. Maiden name Bertie Varkell
15. Birthplace Texas MO
(City, town, or county) (State or foreign country)

16. (a) Informant Lester Cable

(b) Address R#1 Cabool mo.

17. (a) Burial (b) Date thereof Oct 1 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bado cemetery

18. (a) Signature of funeral director Raymond V. Elliott
(b) Address Cabool mo

19. (a) Oct 1-1943 (b) Zon Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1943 1. hour 50 minute P. M.

21. I hereby certify that I attended the deceased from Sept 29 1943 to Sept 30 1943
that I last saw him alive on Sept 30 1943
and that death occurred on the date and hour stated above.

Immediate cause of death cardiac insufficiency 1 day
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 In Edens (M. D. or other)

Address Cabool mo Date signed Oct 1 1943

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

1572

RECEIVED

District Health Officer No. 5,

District File Number. 1043596

Date Filed 10-8-42

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.....

Not embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Lola M. Elliott

Licensed Embalmer No. 2774

P. O. Address..... Cabool, Mo.

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. Oct.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural
(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 2 da. years, months or days)

3. (a) PRINT FULL NAME Colle

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

4. Sex m 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 _____ year

7. Birth date of deceased Sept. 29 - 1943
(Month) (Dpy) (Year)

8. AGE: Years _____ Months _____ 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 _____ (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 Sept 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 _____

Due to cardiac insufficiency Duration 1 day
congenital condition

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 157e

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. E. Deus (M. D. or other) _____

Address cabool mo Date signed Oct 14 43

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

SUPPLEMENTAL

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

32705