

No. 2
9-4-41
5-17-39
FILED

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35583

OCT 19 1943 301

State File No. _____

Registration District No. _____

Primary Registration District No. 6040

Registrar's No. 1925

1. PLACE OF DEATH:
(a) County: Ripley
(b) City or town: Rural, Ripley
(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: 5 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Ripley
(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? No. (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Samuel P. Michals
3. (b) If veteran, L name war: _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept day: 8. year: 1943 hour: 2 minute: 30 P.M.
21. I hereby certify that I attended the deceased from July 18, 1943, to Sept 8, 1943, that I last saw him alive on 9-6-43, and that death occurred on the date and hour stated above.

4. Sex: Male 5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Nellie Michals
6. (c) Age of husband or wife if alive: 69 years
7. Birth date of deceased: Jan. 19, 1853 (Month) (Day) (Year)

Immediate cause of death: Apoplexy cerebral rupture
Due to: _____
Due to: _____
Other conditions: _____ (Include pregnancy within 3 months of death)

8. AGE: Years: 90 Months: 7 Days: 20 If less than one day: _____ hr. _____ min.

Major findings: Of operations: none
Of autopsy: none
PHYSICIAN: _____
Underline the cause to which death should be charged statistically.

9. Birthplace: Muscatine Iowa (City, town, or county) (State or foreign country)
10. Usual occupation: Farming

11. Industry or business: _____
12. Name: Barton Michals
13. Birthplace: Maine (City, town, or county) (State or foreign country)
14. Maiden name: Sarah Lockitt
15. Birthplace: Maine (City, town, or county) (State or foreign country)

16. (a) Informant: Faye Harvey
(b) Address: Maynard Ark.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-10-1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Pratt Cent.

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)
23. Signature: J. Carrene (M. D. or other)
Address: Pittman Ark. Date signed: 9-19-43

18. (a) Signature of funeral director: Blacker Martwing
(b) Address: Dourshan Mo.
19. (a) 9-18-43 (Date received local registrar)
(b) E. O. Johnston (Registrar's signature)

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

MOTHER FATHER

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 Lester D. Russell

Licensed Embalmer No. 3855

P. O. Address Corning Ark.

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.