

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36956

FILED NOV 8 1943

State File No.

Registration District No. 370

Primary Registration District No. 6255

Registrar's No.

1. PLACE OF DEATH:

(a) County Wayne Co.

(b) City or town Hiram, Wayne Co.

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location) 1

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne

(c) City or town Hiram

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Maude Elizabeth Costephens

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, Widow

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

7. Birth date of deceased March, 2, 1882 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>7</u>	<u>1</u>	hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name James Mullins,

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

14. Maiden name Sarah McKitchens,

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

16. (a) Informant Mrs. Essie Sanders, (b) Address Hiram, Mo.

17. (a) Burial (b) Date thereof Oct. 45, 43 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wesley Chappel Cem.

18. (a) Signature of funeral director Watkins Funeral Ser. (b) Address Puxico, Mo.

19. (a) Oct 8 1943 (b) J. Bennett (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 3 year 1943 hour 1 minute P M.

21. I hereby certify that I attended the deceased from Aug 15 to Oct 3, 1943 that I last saw him alive on Oct 1, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Degeneration of Kidneys

Due to Bright's Disease

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? _____

23. Signature Adam F. Wagner (M. D. or other) _____

Address Greenfield, Mo. Date signed 10-7-43

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

MOTHER FATHER

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(Licensed Embalmer's Statement on Reverse Side)

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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 *Charles P. Raaf*

Licensed Embalmer No. *3044*

P. O. Address *Defton 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. Nov
Registrar's No. _____

Registration District No. 370

Primary Registration District No. 62d5

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

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Cowanburg, Ohio
(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 Maudie E. Costephen

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 W

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

7. Birth date of deceased Mar 2 1885
(Month) (Day) (Year)

8. AGE: Years 61 Months 7 Days _____ Unless 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 08 day 13 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death degeneration of kidney *Dysuria*

Due to _____

Due to Bright Disease Chronic

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 Adam F. Wagner MD (M. D. or other) _____

Address Brownville Date signed _____

SUPPLEMENTARY

36056