No. 2
—2-43
5-17-39
I X35697

16
1

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 8 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38349

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 120

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Christa Hagan Hosp.
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ark ~~Mo~~ (b) County ~~Howell~~ Randolph 1943
(c) City or town ~~West Plains~~
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. 2, Ravenden
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Mary M. Nelson

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced 2W

6. (b) Name of husband or wife .....

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

7. Birth date of deceased 8/30 - 1859
(Month) (Day) (Year)

8. AGE: Years 84 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Jordon (City, town, or county) Wise (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Samuel Taylor
13. Birthplace ..... (City, town, or county) N.Y. (State or foreign country)

MOTHER
14. Maiden name Mary Morton
15. Birthplace ..... (City, town, or county) Maine (State or foreign country)

16. (a) Informant Lee Taylor
(b) Address Colorado

17. (a) B. (Burial, cremation, or removal) (b) Date thereof 11-5-43 (Month) (Day) (Year)
(c) Place: burial or cremation Vanagaard, Ark

18. (a) Signature of funeral director Robertson
(b) Address West Plains, Mo

19. (a) 11-15-43 (Date received local registrar) (b) Hail Harlin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 1
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from August 31, 1943, to ....., 19..., that I last saw her alive on November 1, 1943, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchial Pneumonia	1
Due to Chr Fracture Rt Femur	1
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 136
(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 R E Hogan (M.D. or other)
Address West Plains, Mo. Date signed 11-15-43

1125

(Licensed Embalmer's Statement on Reverse Side)

Hagan

RECEIVED
District Health Officer No. 5,
District File Number 1248641
Date Filed 12-7-43

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 D D Roberts

Licensed Embalmer No. 3432

P. O. Address Mesa Plains, N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 120

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Howell

(b) City or town West Plains
(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 years, months or days)

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

3. (a) PRINT FULL NAME Mary M. Nelson

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 Aug (Month) 30 (Day) 1859 (Year)

8. AGE: Years 84 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day
year 1943 hour 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.

Immediate cause of death Bronchial pneumonia

Due to Chr. fracture rt. femur

Due to

Other conditions
(Include pregnancy within 3 months of death)

186a

Major findings:
Of operations

Of autopsy

Duration

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?
In home (Specify type of place)
While at work? Yes (e) Means of injury Fall

23. Signature R E Hogan M.D. (M. D. or other)

Address Date signed

38349