

No. 2
14
5-17-39
X36671

NOV 18 1943

Registration District No. **814**

Primary Registration District No. **6064**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Osceola 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 acc of Lake (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Clair

(c) City or town Osceola 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 MARY J. Todd

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 31
year 1943 hour 12 minute A.M.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Devon D. Todd

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

7. Birth date of deceased: Jan 13 1854
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 1940 to Oct 31, 1943
that I last saw her alive on Oct 29, 1943
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>89</u>	<u>9</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death: Senility

Due to _____

Due to _____

9. Birthplace St. Clair Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeping

Other conditions injury to leg in fall
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

11. Industry or business:

12. Name Joseph North

13. Birthplace Not known
(City, town, or county) (State or foreign country)

14. Maiden name Janet Jones

15. Birthplace Not known
(City, town, or county) (State or foreign country)

Of autopsy _____

22. If death was due to external causes, fill in the following:

16. (a) Informant Jeff Todd

(b) Address Osceola Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-1-43
(Month) (Day) (Year)

(c) Place: burial or cremation Emp. Home

18. (a) Signature of funeral director Joseph Stinner

(b) Address Osceola Mo

19. (a) 11-1-43 (Date received local registrar) (b) W. Bloodworth (Registrar's signature)

PHYSICIAN

Underline the cause to which death should be charged statistically.

(a) Accident, suicide, or homicide (specify) -093V

(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 Rich Seaman (M. D. Seaman)
Address Osceola Mo Date signed 11/1/43

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

MOTHER FATHER

1100

RECEIVED

Health Officer No. 7.

Case File Number 10-43-1270

Date Filed 11-15-43

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 J. B. Bealick

Licensed Embalmer No. 3038

P. O. Address Osceola Md

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. Dec.

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

1. PLACE OF DEATH:
 (a) County St. Clair
 (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 _____
years, months or days)

3. (a) PRINT FULL NAME Mary G. Todd
 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 W

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

7. Birth date of deceased Jan. 13 - 1891
(Month) (Day) (Year)

8. AGE: Years 89 Months 9 Days _____
If less than one day

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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 Oct. Year 1943
 year _____ 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 senility

injury to leg in fall
 Due to _____

Due to _____

Other conditions _____
(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 about Aug 1st 43

(c) Where did injury occur? in house Orceola
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in house

While at work? _____ (Specify type of place)
 (e) Means of injury fell on floor

23. Signature Ruth Secura (M. D. or other) _____

Address Orceola Mo Date signed 11-27

1943

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

SUPPLEMENTARY

S-39023