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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED DEC 27 1943

Registrar's No. 354

Registration District No. 43

Primary Registration District No. 30 5135

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

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Paulina, Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home 1 Ash Hill Farm  
(If not in hospital or institution, write street number or location)

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

In this community most of life years, months or days \_\_\_\_\_ (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12

(c) City or town Paulina Mo. 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 ANN BINKLEY

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28 year 1943 hour 10 minute P.M.

4. Sex Female 5. Color or race White

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

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

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

7. Birth date of deceased June 19 - 1860  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 10 1943 to Nov. 28 1943 that I last saw him alive on Nov. 28 1943 and that death occurred on the date and hour stated above.

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

83 5 10 hr. min.

Immediate cause of death Cerebral Hemorrhage Duration 18 days

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) J3a1

10. Usual occupation Homemaker

11. Industry or business \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name ask.

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

14. Maiden name ask.

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant H. C. Binkley

(b) Address Paulina

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-43 (Month) (Day) (Year)

(c) Place: burial or cremation Four Mile

18. (a) Signature of funeral director Lundstrom

(b) Address Campbell Mo.

19. (a) 12-7-43 (Date received local registrar) (b) Belle Ferme (Registrar's signature)

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 H. J. Pethledge (M. D. or other) MD

Address Campbell Mo. Date signed 12/6/43

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RECEIVED

District Health Office No. 2,

District File Number 1243-1580

Date Filed 12-23-43

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 Christina M. Landers

Licensed Embalmer No. 4227

P. O. Address Campbell, 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.