

No. 2
9-4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3279**

FILED JAN 26 1944
Registration District No. **158**

Primary Registration District No. **5-5-9-5590**

Registrar's No. **171**

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

1. PLACE OF DEATH

(a) County **Jefferson**
 (b) City or town **Waver (Rural) Big River Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (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 **12 years** (Specify whether years, months or days)
 In this community **12 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jefferson**
 (c) City or town **Subville Mo. Rt. #1**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **(2 mi. West of Waver Mo.)**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME **MAUDE BRANCH**
 (b) If veteran, name war **✓**
 (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **Jan** day **16**
 Year **1944** hour **10** minute **42 p.m.**
21. I hereby certify that I attended the deceased from
8/19, 19**42** to **1-16**, 19**44**
 that I last saw her alive on **1-16-44**, 19**44**
 and that death occurred on the date and hour stated above.

4. Sex **F** **5. Color or race** **W** **6. (a) Single, widowed, married** **1 divorced** **Married**
(b) Name of husband or wife **R. William Branch** **6. (c) Age of husband or wife if alive** **55** years
7. Birth date of deceased **Oct. 19, 1874**
 (Month) (Day) (Year)

Immediate cause of death **Permeous Anemia** **15yr**

8. AGE: Years **69** Months **2** Days **27** If less than one day hr. min.

Due to **173a**

9. Birthplace **ava Illinois**
 (City, town, or county) (State or foreign country)

Other conditions **Essential Hypertension?**
 (Include pregnancy within 3 months of death)

10. Usual occupation **at home**
11. Industry or business
12. Name **Frank Jones**
13. Birthplace **Chester Illinois**
 (City, town, or county) (State or foreign country)
14. Maiden name **Mary Ann Cleander**
15. Birthplace **Rothwood Illinois**
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **R. William Branch**
(b) Address **Subville Rt. 1**
17. (a) (burial, cremation, or removal) **burial** (b) Date thereof **Jan 19 1944**
 (Month) (Day) (Year)
(c) Place: burial or cremation **St. Johns Cemetery, Milledale Mo.**
18. (a) Signature of funeral director **Donald B. Dineen**
(b) Address **Subville Mo.**
19. (a) Jan 24-44 (b) **A. N. Eaton**
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **1**
(b) Date of occurrence **1-16-44**
(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 **Chas E. Falter** (M.D. or other) **0**
Address **Dr. Letz Mo.** **Date signed** **1/18/44**

580

OCT 20 1958

DEC 18 1958

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..... *Arnold B Dietrich*.....
Licensed Embalmer No. *4104*.....
P. O. Address *Delato 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.