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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 15 1944

# MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. 6710

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 68

**1. PLACE OF DEATH:**

(a) County Callaway

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

(c) Name of hospital or institution:  
State Hospital #12  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-19-40  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Shelby

(c) City or town Shelbyville  
(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 Backeiser

3. (b) If veteran, name war D.K. 3. (c) Social Security No. D.K.

4. Sex Female 5. Color W 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased ? (Month) (Day) (Year) 1964

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 17 year 1944 hour 10 minutes 0 M.

21. I hereby certify that I attended the deceased from 11-23-43 to 2-17-44 1944  
that I last saw alive on 2-17-44 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction  
catarrhal of indistinct

Duration \_\_\_\_\_

**8. AGE:**

Years	Months	Days	If less than one day
<u>7</u>	<u>00</u>		hr. _____ min. _____

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace 875 9  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

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

MOTHER FATHER

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

12. Name OTK

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

14. Maiden name OTK

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

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? \_\_\_\_\_

16. (a) Informant Record

(b) Address \_\_\_\_\_

17. (a) Removal (b) Date thereof 2-18/1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Mo

18. (a) Signature of funeral director J. O. Roberts

(b) Address Columbia Mo

19. (a) 2-18-1944 (b) Jane Morison  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature J. E. Starnell (M. D. or other) \_\_\_\_\_

Address Fulton Mo Date signed 2/17/44

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 3-14-44

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**