

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

INDIAN STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6737

State File No. _____

FILED MAR 15 1944

Registration District No. 4

Primary Registration District No. 2008

Registrar's No. 58

14
1
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Callaway

(b) City or town Sheldon

(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 of institution 6-22-43
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Cooper

(c) City or town Pilot Grove
(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 Meyer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 8, year 1944, hour 3.30 minute _____ M.

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan 30 - 1863 - 67
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-18-1943 to 2-9-1944
that I last saw him alive on 2-9-1944 and that death occurred on the date and hour stated above.

Immediate cause of death chronic myelocarcinosis

Duration _____

8. AGE: Years 67 Months ? Days _____ If less than one day hr. _____ min. _____

Due to _____

Due to _____

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

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

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation _____

11. Industry or business _____

12. Name Anthony Hoag

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

14. Maiden name Dev

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

16. (a) Informant Brook

(b) Address _____

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Feb 17 - 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Pilot Grove Mo

18. (a) Signature of funeral director Godward Baker

(b) Address Boonville Mo

19. (a) 2-12-1944 (Date received local registrar)

Joan Moushuff (Registrar's signature)

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? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature H. E. Sherrill (M. D. or other) _____

Address Sheldon Ind Date filed 2/19/44

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 J. H. Goodman

Licensed Embalmer No. 1178

P. O. Address Boonville 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.