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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 APR 7 1944
Registration District No. _____

Primary Registration District No. 8306

Registrar's No. 41

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

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Phillipsburg Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wilson Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 5 months years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Phillipsburg Rural
(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 GOLDA MAY RESOR

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Harry Resor 6. (c) Age of husband or wife if alive: 41 years
7. Birth date of deceased May 11 1903
(Month) (Day) (Year)

8. AGE: Years 40 Months 6 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Clayton Co. Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name John Combs
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Harry Resor
(b) Address Phillipsburg Mo

17. (a) Burial (b) Date thereof Mar 8 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope

18. (a) Signature of funeral director L. B. Jones

(b) Address Buffalo Mo

19. (a) March 29 1944 (b) Miss A. L. Hoover
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 5 year 1944 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

that I last saw _____ alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Died without medical attention
Due to Child birth of twin punctured Hemorrhage

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

Major findings: Of operations 1460
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury B

23. Signature J. Adams Combes (M. D. or other)
Address Buffalo Mo Date signed 3-6-44

1124

Health Office
District No. 3-44-320
Date Filed 4-5-44

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 Charles R. Roof
Licensed Embalmer No. 304X
P. O. Address Buffalo 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.