

No. 2
5-43
17-39
X36871

FILED APR 12 1944
Registration District No. 127

Primary Registration District No. 5586

Registrar's No. 69

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

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:
Route 3, Carthage
(If not in hospital or institution, write street number or location)

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

In this community 75 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Rural
(If outside city or town limits, write "RURAL") 3

(d) Street No. Route 3, Carthage
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - 0

3. (a) PRINT FULL NAME Emma Davis Royer

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 9
year 1944 hour 11:30 minute PM

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Thomas A. Royer

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

7. Birth date of deceased March 16 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 5, 1944, to Mar 9, 1944
that I last saw her alive on Feb 19, 1944,
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>11</u>	<u>23</u>	_____ hr. _____ min.

Immediate cause of death Pneumonia ✓

Duration 3 weeks

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

Due to _____

Due to _____

10. Usual occupation At Home

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

11. Industry or business None

Major findings: _____

12. Name Morgan L. Davis

Of operations _____

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

Of autopsy _____

14. Maiden name Catherine Lyons

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

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

22. If death was due to external causes, fill in the following:

16. (a) Informant Carl C. Royer

(a) Accident, suicide, or homicide (specify) _____

(b) Address Route 3, Carthage, Missouri

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof Mar. 12, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? _____
(City or town) (County) (State)

(c) Place: burial or cremation Ludman Cemetery

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director Knell Mortuary

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

(b) Address Carthage, Missouri

23. Signature J. E. Boyd (M. D. or other) _____
Address Carthage, Mo Date signed 3-10-44

19. (a) Mar. 11 '44 (b) Elizabeth Complin
(Date received local registrar) (Registrar's signature)

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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.....

Emm R. Streef

Licensed Embalmer No.....

391

P. O. Address.....

Parthage

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. !

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. _____

Registration District No. 157 Primary Registration District No. 5586

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

1. PLACE OF DEATH:
 (a) County Jasper
 (b) City or town Clarks, Marion Twp.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Emma Davis Payer
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased march 16 1908
(Month) (Day) (Year)

8. AGE: Years 85 Months 11 Days 3 if less than one day
 or _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death Pneumonia
lobar

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

Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
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

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

11268