

No. 2
M-2-43
5-17-39
I X35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 18 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18779

State File No. _____
Registrar's No. _____

Registration District No. 254

Primary Registration District No. 4385

1. PLACE OF DEATH:
(a) County Oregon
(b) City or town Koshkonong
(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)
In this community 30 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Oregon
(c) City or town Koshkonong
(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 Tiney Mask
3. (b) If veteran, name war --
3. (c) Social Security No. --

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 21
year 1944 hour 12 minute 55 P.M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Robert Mask
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased Sept. 19 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 1944 to March 17 - 1944
that I last saw him alive on March 17 - 1944
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

8. AGE: Years 73 Months 6 Days 2
If less than one day _____ hr. _____ min.

Due to Corneo-Vascular disease
Due to _____

9. Birthplace Arkansas
(City, town, or county) (State or foreign country)
10. Usual occupation Domestic

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

MOTHER, FATHER { 12. Name Fount Simpson
13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Mary Feldon
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

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

16. (a) Informant Earl Mask
(b) Address Koshkonong, Mo.
17. (a) Burial (b) Date thereof 3/23/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Koshkonong Cem.
18. (a) Signature of funeral director Geo. Carr
(b) Address Thayer, Mo.
19. (a) 4-6-44 (b) Jae W. Williams
(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) _____
(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 H. B. Hull (M. D. or other) _____
Address Manmoth Spring Ark Date signed 4/4/44

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

75
0
0

75
0
0

111

Hull

RECEIVED

District Health Officer No. 5,

District File Number 544312

Date Filed 5-17-44

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.