DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 13 1944

Registration District No. 190

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21666

Primary Registration District No. 3024

Registrar's No. 43

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

1. PLACE OF DEATH:

(a) County Howard,

(b) City or town Fayette, Mo.
(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) 1

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Howard, 45

(c) City or town Fayette, Mo. 1
(If outside city or town limits, write "RURAL") 1

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mrs Willie Routt,

3. (b) If veteran, name war 1

3. (c) Social Security No.

4. Sex Female,

5. Color or race White,

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July 6th 1857 (Month) (Day) (Year)

8. AGE: Years 86 Months II Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

MOTHER

14. Maiden name

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

16. (a) Informant Mrs George Todd,

(b) Address Fayette, Mo.

17. (a) Burial. (Burial, cremation, or removal) (b) Date thereof 6 - 10th 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Guy T. Halley.

(b) Address Fayette, Mo.

19. (a) 6-21-1944 (Date received local registrar) (b) Ernest McWilliams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6-8-44 day year hour 10 minute 10 A.M. P.M.

21. I hereby certify that I attended the deceased from 5-13, 1944, to 6-8, 1944 that I last saw he alive on 6-8, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to Chr. Myocarditis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

93d

Duration 3 days

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 Ira Bloom (M. D. or other) M.D.

Address Fayette, Mo. Date signed 6-19-44

(Licensed Embalmer's Statement on Reverse Side)

1321

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 7-12-44

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Form No. 2B
5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 43

1. PLACE OF DEATH:

(a) County: Howard

(b) City or town: Fayette (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)

In this community

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

3. (a) PRINT FULL NAME: Mrs Willie Reuth

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: July (Month) (Day) 18 (Year)

8. AGE: Years 86 Months 11 Days If less than one day: hr. min.

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

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: unknown

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

MOTHER

14. Maiden name: unknown

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Ernest W. Wallace (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1944 hour 10 minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

216666