

S. No. 2  
M-8-43  
5-17-39  
I X37823

22221

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 210

FILED JUL 10 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3052

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

1. PLACE OF DEATH:  
(a) County PETTIS  
(b) City or town SEDALIA  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
400 WEST MORGAN  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days 60 YRS (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County PETTIS 80  
(c) City or town SEDALIA  
(If outside city or town limits, write "RURAL")  
(d) Street No. 400 W MORGAN  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EDWARD BLACK  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_  
4. Sex MALE 5. Color or race NEGRO  
6. (a) Single, widowed, married, divorced MAR.  
(b) Name of husband or wife LULA  
(c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 3 23 1872  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 23 day June  
year 1944 hour 11 minute 30 P. M.  
21. I hereby certify that I attended the deceased from 6/23  
1944 to 6/23 1944  
that I last saw him alive on 6/23 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 3 Days 0  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Apoplexy  
Due to Arteriosclerosis  
Due to \_\_\_\_\_

9. Birthplace VER SAILLES (City, town, or county) Mo (State or foreign country)  
10. Usual occupation RETIRED  
11. Industry or business LABORER, Mo P. R.R.  
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)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: none  
Of operations none  
Of autopsy none

16. (a) Informant LULA BLACK  
(b) Address SEDALIA, Mo  
17. (a) BURIAL (b) Date thereof 6-26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CLEYNWOOD CEM.  
18. (a) Signature of funeral director GILLESPIE, F. H.  
(b) Address SEDALIA, Mo  
19. (a) 6-24-44 (b) Mrs Anna Berger  
(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 M. D. [unclear] (M. D. or other) \_\_\_\_\_  
Address 118 1/2 W Main Sedalia, Mo Date signed 6/24/44

Physician \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 87  
District File Number  
Date Filed

JUL 11 1944

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 *Geo Dillard*  
Licensed Embalmer No. *3868*  
P. O. Address *Sevulia, 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.