

22643

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 2
39
X35897

FILED JUL 13 1944
Registration District No. 13044

Primary Registration District No. 3072

Registrar's No. 114

1. PLACE OF DEATH:

(a) County Saline

(b) City or town marshall
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fitzgibbon Memorial Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 da (Specify whether 0)

In this community 27 yr
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline 97

(c) City or town marshall 1
(If outside city or town limits, write "RURAL") 2

(d) Street No. 445 N. Russell
(If rural, give location)

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

If yes, name country 11

3. (a) PRINT FULL NAME SAM ESTES

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

4. Sex 0 m 5. Color or race W 6. (a) Single, widowed, married, divorced 2 widowed

6. (b) Name of husband or wife ALICE PEAS ESTES 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct - 23 - 1880
(Month) (Day) (Year)

8. AGE: Years 63 Months 7 Days 18 If less than one day hr. min.

9. Birthplace Patton County mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Employer

11. Industry or business marshall & Co

MOTHER FATHER

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Samuel O. Estes
(b) Address marshall mo

17. (a) Burial (b) Date thereof 6-7-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation marshall mo Sunset Memorial
Franklin

18. (a) Signature of funeral director Harry Heubler

(b) Address marshall mo

19. (a) 6/12/1944 (b) Mrs T.O. Weathers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11
year 1944 hour 10:35 minute P M.

21. I hereby certify that I attended the deceased from June 8
1944 to June 11 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism
instantly following amputation

Due to.....

Due to.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions (Include pregnancy within 3 months).....

Major findings: Amputation of leg
Of operation for gangrene

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? no (Specify type of place) (e) Means of injury.....

23. Signature John H. Taylor (M. D. or other).....
Address marshall Date signed 6/13/44

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

1211

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 7-11-1968

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 Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 114

Registration District No. 224

Primary Registration District No. 3072

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

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

Sam Ester

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

4. Sex m 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 Oct 23 1884
(Month) (Day) (Year)

8. AGE: Years 63 Months 7 Days _____ If less than one day _____ min.

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

10. Usual occupation

11. Industry or business

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

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 _____ year 1944 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 Pulmonary embolism Duration Instantly

Due to following amputation

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death) 98:2

22. Major findings: amputation of leg Underline cause to which death should be charged statistically.
Of operations for gangrene - following
Of autopsy thrombosis

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? _____

23. Signature _____ (M, D, or other) _____
While at work? _____ (Specify type of place)
(e) Means of injury _____
Address _____ Date signed _____

SUPPLEMENTARY

22643