

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 20 1944
Registration District No. _____

Primary Registration District No. 5117

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution:
Ashland No. P. F. D. #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community Life 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. Ashland No. P. F. D. #1 0
(If rural, give location)

(e) Citizen of foreign country? NI (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mattie Shouse

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 13
year 1944 hour 8 minute 45 P.M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Henry Shouse 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: June 9 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1 1943 to June 13 1944, that I last saw her alive on June 10 1944 and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 5 Days 4 If less than one day _____ hr. _____ min.

Immediate cause of death: Cerebral hemorrhage

Due to _____

Due to _____

9. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

Major findings: none

Of operations _____

Of autopsy none

11. Industry or business _____

12. Name Mrs. Henshaw

13. Birthplace Unknown

14. Maiden name Elizabeth Taylor

15. Birthplace Unknown

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Elsworth Shouse

(b) Address Ashland Mo.

17. (a) Burial (b) Date thereof 6/15/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Willersguth Cem.

18. (a) Signature of funeral director W. F. Burmitt

(b) Address Ashland Mo.

19. (a) 6/15/44 (b) Mrs. Alice Estes
(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) Means of injury _____

23. Signature W. F. Burmitt (M; D. or other) _____
Address Ashland Mo. Date signed 6-14-44

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

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RECEIVED

District Health Officer No. 9,

District File Number

Date Filed 7-18-44

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 me

Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 3564

P.O. Address Rockland 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.