

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 14 1944

Primary Registration District No. 5866

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Myrtle Imp  
(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 \_\_\_\_\_)  
In this community 78 years (Specify whether \_\_\_\_\_)  
years, months or days)

3. (a) PRINT FULL NAME George Washington Underwood

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex Male 0

5. Color or race White 2

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

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

6. (b) Name of husband or wife Nancy Dobbs

7. Birth date of deceased Sept. 19 1861  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
82	9	2	_____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name George Underwood 9

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 H. N. Underwood

(b) Address Myrtle, Mo.

17. (a) Burial (b) Date thereof 6/23/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Myrtle, Mo. Cem.

18. (a) Signature of funeral director Geo. Darr  
(b) Address Thayer, Mo.

19. (a) 7-14-44 (b) Geo D. Arms  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75

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

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

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21  
year 1944 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from May 1  
1944 to June 21 1944  
that I last saw him alive on June 19 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate

Due to Hypertensive Heart Disease

Due to General Atherosclerosis

Other conditions Stroke - Anger

(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: 51 f

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Geo. Darr (M. D. or other) MDP

Address Thayer, Mo. Date signed 7-1-44

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

7500

RECEIVED

District Health Officer No. 5

District File Number 844439

Date Filed 8-12-44

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**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.