

FILED AUG 8 1944
Registration District No. **2946**

Primary Registration District No. **6208**

Registrar's No. **26**

1. PLACE OF DEATH:
(a) County **Texas**
(b) City or town **Summersville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OZARK TWP, none
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Texas**
(c) City or town **Summersville, Texas**
(If outside city or town limits, write "RURAL")
(d) Street No. **RURAL**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Catherin J. Caldwell**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **6** day **12**
year **44** hour _____ minute _____
21. I hereby certify that I attended the deceased from **June 5 to June 12**, 19**44**, to **June 12**, 19**44**
that I last saw h. _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **W**
6. (b) Name of husband or wife **0**
6. (c) Age of husband or wife if alive **32** years
7. Birth date of deceased **Mon 31 44**
(Month) (Day) (Year)

Immediate cause of death **abductor**
Duration _____

8. AGE: Years _____ Months _____ Days **8**
If less than one day _____ hr. _____ min.

Due to **Rapture of Cord**

9. Birthplace **Summersville MO**
(City, town, or county) (State or foreign country)

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

10. Usual occupation _____
11. Industry or business _____
12. Name **Blenn Ayson**
13. Birthplace **Yona Ga**
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

Major findings:
Of operations **161a**
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Wlen Ayson Father**
(b) Address **Summersville**
17. (a) **Rural** (b) Date thereof **6-12-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Summersville**
18. (a) Signature of funeral director **Wlen Ayson**
(b) Address **Summersville MO**
19. (a) **7-10-44** (b) **Mrs. Ella Duff**
(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 **Dr. Lucien Blumstein D. O.**
Address **Summersville** Date signed **June 14**

MOTHER FATHER

1240

RECEIVED

District Health Officer No. 5

District File Number

844.420

Date Filed

8.7.44

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 complete 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. Aug
Registrar's No. 26

Registration District No. 356

Primary Registration District No. 6208

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Ozark Twp. Rural
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Cathan Arson

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

4. Sex J 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased May 31
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ 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 _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs. Ella Duff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town Lumbersville - Rural
(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 June 1944
year 1944 hour _____ 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 _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

25948