

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27928
Registrar's No. 111

FILED SEP 10 1944
Registration District No. 150

Primary Registration District No. 5572

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural Prairie
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson County Eng Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community 72 yrs. (Specify whether
years, months or days)

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

3. (a) PRINT FULL NAME EMMA F. George
3. (b) If veteran, name war No
3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 14th
year 1944 hour 11 minute 30 A.M.
21. I hereby certify that I attended the deceased from August
9-1944, 19____, to Aug 14, 1944,
that I last saw her alive on Aug 14, 1944,
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Wh.
6. (a) Single, widowed, married 2 divorced Widowed
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased August 12th 1856
(Month) (Day) (Year)

Immediate cause of death Relational Bronchitis
pneumonia
Due to _____
Due to _____

Duration 7 da

8. AGE: Years 87 Months 0 Days 2
If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death)
Major findings: 107
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Wright
13. Birthplace Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Cruse
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant J. C. Hospital Records

(b) Address 1144 E. 11th St., Missouri

17. (a) Burial (b) Date thereof 8-16-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buckner Mo.

18. (a) Signature of funeral director J. M. Reppert
(b) Address Buckner Mo.

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?

19. (a) Aug. 14, 1944 (b) F. M. Schick
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature F. M. Schick (M. D. or other) MD
Address Buckner Mo. Date signed 8-14-44

1162 (Licensed Embalmer's Statement on Reverse Side)

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 Personally

~~working under my personal supervision.~~

Registered Apprentice No. _____

Signed _____

J. M. Reppert

Licensed Embalmer No. 2321

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.