

FILED SEP 9 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28968

State File No.

Registration District No. 349

Primary Registration District No. 6177

Registrar's No. 7

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Buchanan Rural
(c) Name of hospital or institution:
near Green Castle
(d) Length of stay: In hospital or institution.....
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Sullivan
(c) City or town Rural
(d) Street No. near Green Castle
(e) Citizen of foreign country? no.
If yes, name country 0

3. (a) PRINT FULL NAME MAE MAGDELENE BACHMAN
3. (b) If veteran, name war ✓
3. (c) Social Security No. —

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month AUG day 5 year 1944 hour 4:00 minute 19 A. M.
21. I hereby certify that I attended the deceased from AUG 3 to AUG 5 1944
that I last saw her alive on AUG 5 1944
and that death occurred on the date and hour stated above.

4. Sex 7 5. Color or race 1
6. (a) Single, widowed, married, divorced Single
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased 4 3 1944
(Month) (Day) (Year)

Immediate cause of death BRONCHIAL PNEUMONIA
Duration 4 days

8. AGE: Years 6 Months 4 Days 2
If less than one day hr. min.

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death).....
Major findings: Of operations.....
Of autopsy.....

9. Birthplace Sullivan Co Mo
10. Usual occupation.....

11. Industry or business.....
12. Name Sam Bachman
13. Birthplace Mo
14. Maiden name Madeline Purrys
15. Birthplace Mo

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

16. (a) Informant Mae Bachman
(b) Address Green Castle Mo
17. (a) Burial (b) Date thereof 8-6-1944
(c) Place: burial or cremation Morelock Cem
18. (a) Signature of funeral director Glen E Kent & Son
(b) Address Green City Mo
19. (a) AUG 31-1944 (b) Paul M. Shaw - deputy
(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?.....
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? Yes (Specify type of place) (e) Means of injury 2
23. Signature [Signature] (M. D. or other) 2
Address Green City Mo Date signed 8-5-44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 9-44-1504

Date Filed SEP 5 1944

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

Archie W. Wade

Licensed Embalmer No.

3037

P. O. Address

Green City, 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.

Registration District No. 349

Primary Registration District No. 6177

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Lillyman
(b) City or town Buchanan Twp
(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 Life
years, months or days)

3. (a) PRINT FULL NAME Mae M. Bachman

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

4. Sex 7 5. Color or race White 6. (a) Single, widowed, married, divorced 5

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

7. Birth date of deceased April 3 (Month) (Day) (Year)

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

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

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Aug 31-44 (b) Laura Shaw de... (Date received local registrar) (Registrar's signature)

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 Sept year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: 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 Dr. H. G. Schurr (M. D. or other) _____
Address Greasy City, Mo. Date signed 9-5-44

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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