

S. No. 2  
M-2-43  
5-17-39  
X3569

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED OCT 13 1944**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30686

State File No. \_\_\_\_\_  
Registration District No. 53 Primary Registration District No. 3011 Registrar's No. 83

1. PLACE OF DEATH:  
(a) County Carroll  
(b) City or town Carrollton  
(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 2 months years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Hickory  
(c) City or town Weaubleau  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Missie May John  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 13  
year 1944 hour 9 minute 00 A.M.

4. Sex Fe 5. Color or race W  
6. (a) Single, widowed, married, divorced Widow  
(b) Name of husband or wife J. O. John (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 2 1879 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to Sept 13 1944, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
64 10 11 hr. \_\_\_\_\_ min.

Immediate cause of death Undulant fever  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Mo. W (City, town, or county) (State or foreign country)  
10. Usual occupation at home

Other conditions (include pregnancy within 3 months of death) 5

11. Industry or business  
12. Name Jasper Fentress  
13. Birthplace Mo. W (City, town, or county) (State or foreign country)  
14. Maiden name Isabelle Murphy  
15. Birthplace Indiana (City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Max Jess Coffey  
(b) Address Carrollton, Mo.  
17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof 9-17-44 (Month) (Day) (Year)  
(c) Place: burial or cremation Weaubleau Mo.  
18. (a) Signature of funeral director Stanley  
(b) Address Carrollton Mo.  
19. (a) 9-14-44 (Date received local registrar) (b) Miss Janice Rafferty (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 W. H. [unclear] (M. D. or other) Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration 1 yr.  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

REC-1071

District Health Officer No. 8,

District File Number

Date Filed

10-11-44

**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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton 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.**