

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31545

State File No.

Registration District No. 290

Primary Registration District No. 4427

Registrar's No. 92

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Waynesville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Dewitts Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community U
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion Co
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Meta, Mo.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26
year 1944 hour 5 minute 15.9 M.
21. I hereby certify that I attended the deceased from June 5
1944, to Sept 26, 1944;
that I last saw her alive on Sept 26, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death
Post partum Hemorrhage
following Cesarean section
Due to Placenta Praevia
Duration 15 minutes
8 months

Other conditions 8 months pregnancy
(Include pregnancy within 3 months of death)
Major findings:
Of operations 1492
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? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Wm. A. Gould (M.D. or other) DO.
Address Meta Mo Date signed 4/27

3. (a) PRINT FULL NAME LILLIAN BAX
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Fem 5. Color or race white 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Thomas Bax 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased Sept 6 1917
(Month) (Day) (Year)

8. AGE: Years 27 Months _____ Days 20 If less than one day
hr. _____ min. _____

9. Birthplace Meta Mo U
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business Farm

12. Name James Robertson
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Virginia Vaughan
15. Birthplace Meta Mo U
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Bax
(b) Address Meta, Mo

17. (a) Burial (b) Date thereof 9-28-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Meta, Mo

18. (a) Signature of funeral director Ch. Casey
(b) Address Meta Mo

19. (a) 10-2-1944 (b) Lois M. Dodd
(Date received local registrar) (Registrar's signature)

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

1500

1170

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 Ch Casey.....

Licensed Embalmer No. 2694.....

P. O. Address Berea, MD.....

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.