No. 2
8-43
17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 14 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35031

Registration District No. 278 Primary Registration District No. 4413 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Frankford
(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) 1
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pike 92
(c) City or town Frankford 0
(If outside city or town limits, write "RURAL") 0
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mary (Mollie) Douglass
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F 1
5. Color or race White
6. (a) Single, widowed, married, divorced 9
6. (b) Name of husband or wife Jarve Douglass
6. (c) Age of husband or wife if alive 87 years
7. Birth date of deceased Feb (Month) 21 (Day) 1860 (Year)

8. AGE: Years 84 Months 8 Days 7 If less than one day hr. min.

9. Birthplace Near Frankford (City, town, or county) Pike Mo 0 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Thomas D. Shy
13. Birthplace Kentucky (City, town, or county) 1 (State or foreign country)
MOTHER 14. Maiden name Minerva Busby
15. Birthplace (City, town, or county) Missouri 0 (State or foreign country)
16. (a) Informant Mrs Ray Graves
(b) Address Frankford Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Frankford Missouri
18. (a) Signature of funeral director Fields and son
(b) Address Frankford Missouri
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10th day 28th year 1944 hour 5:00 minute A. M.
21. I hereby certify that I attended the deceased from October 2, 1944 to Oct 28th, 1944 that I last saw her alive on Oct 27th, 1944; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death
Myocardial failure with a generalized debilitated condition
Due to
Melano-Sarcoma of the
Due to posterior Superior Surface of the Scalp.
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations 53
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 Peter A. Hopkins (M. D. or other) DO
Address Frankford, Mo. Date signed 10-30-44

1169

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 11-44-1891
Date Filed NOV 10 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 Jane Fields Megown

Licensed Embalmer No. 4093

P. O. Address Frankford, 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.

. S. No. 2B
0M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

new

State File No. ____

Registration District No. 278 Primary Registration District No. 4413 Registrar's No. ____

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Frankford

(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 years, months or days)

In this community ____

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 ____

3. (a) PRINT FULL NAME Mary M. Douglass

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced ____

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Feb (Month) 21 (Day) 1860 (Year)

8. AGE: Years 84 Months 8 Days ____ If less than one day ____ min.

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

10. Usual occupation ____

11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____
(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) Nov. 1 - 1944 (Date received local registrar) (b) Mrs R. C. Hohman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 28 year 1944 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____ to ____, 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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature ____ (M. D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY

35031