

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 60

FILED DEC 18 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 3015

1. PLACE OF DEATH:

(a) County Clinton

(b) City or town Cameron, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: East 4th St.  
(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 \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. East 4th.  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Salina Neff.

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10th.  
year 1944 hour 2 minute 0 A. M.

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: November 26th 1857  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ 19 \_\_\_\_\_ that I last saw him alive \_\_\_\_\_ and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>II</u>	<u>I4</u>	hr. _____ min. _____

Immediate cause of death: myocarditis

Due to 93%

Due to Arteriosclerosis

Other conditions: none  
(Include pregnancy within 3 months of death)

9. Birthplace: Wayne Co. Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation: Housework

11. Industry or business \_\_\_\_\_

Major findings: none

Of operations \_\_\_\_\_

Of autopsy: none

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

12. Name Joseph Walters

13. Birthplace Unknown Pa.  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Raudebaugh

15. Birthplace Wayne Co. Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Chas Taylor

(b) Address Cameron, Mo.

17. (a) Removal (b) Date thereof 11-13-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thomas Okla

18. (a) Signature of funeral director Ed Moore

(b) Address Cameron, Mo.

19. (a) Nov. 11, 1944 (b) Mrs. Kathleen Harris  
(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? \_\_\_\_\_  
(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 [Signature]  
Address \_\_\_\_\_

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

**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 \_\_\_\_\_  
*O. Moore*

Licensed Embalmer No. *1180*

P. O. Address *Cameron 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.**