

FILED DEC 16 1944

Registration District No. 1

Primary Registration District No. 4243

1. PLACE OF DEATH:

(a) County Weberster
(b) City or town Seymour Mo
(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 1
(Specify whether

In this community 37 yrs
years, months or days)

3. (a) PRINT FULL NAME Cristina Elizabeth McCarty

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 Widow

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

7. Birth date of deceased Nov 8 1962
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 11 23 hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business

MOTHER FATHER { 12. Name Delos Crisman
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Bert McCarty

(b) Address Sedalia Mo R 2

17. (a) Burial (b) Date thereof Oct 31 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gowrie Iowa

18. (a) Signature of funeral director Kelley Ferrell

(b) Address Seymour Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Weberster 11.2
(c) City or town Seymour Mo
(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 Oct day 29 year 1944 hour 5 minute _____ a.m.

21. I hereby certify that I attended the deceased from April 26, 1942, to Oct 28, 1944 that I last saw her alive on Oct - 28, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration 3 yrs

Due to _____

Due to 93d

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?

While at work _____ (Specify type of place) (b) Means of injury _____

23. Signature Dr J R Hill (M. D. or other) Dr
Address Seymour Date signed 10/29/44

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

RECEIVED

District Health Officer No. 6,

District File Number 1244-1348

Date Filed DEC 12 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

H. H. Keller

Licensed Embalmer No.

3334

P. O. Address

Seymour 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 42362Registration District No. 312Primary Registration District No. 4543Registrar's No. 19

1. PLACE OF DEATH:

(a) County Whester
(b) City or town Seymour
(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 37 yrs
years, months or days3. (a) PRINT FULL NAME Cristina E. McCarty

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 u6. (b) Name of husband or wife Albert 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased Nov. 8
(Month) (Day) (Year)8. AGE: Years 81 Months 11 Days _____ If less than one day _____ min.9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Housekeeper12. Name Solomon Crisman13. 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 Bert McCarty(b) Address Sedalia, Mo17. (a) (Burial, cremation or removal) _____ (b) Date thereof 10-31-44
(Month) (Day) (Year)(c) Place: burial or cremation Home, Iowa18. (a) Signature of funeral director Kelley Ferrell(b) Address Seymour, Mo.19. (a) Nov 12 (b) Gilbert Jones
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Whester(c) City or town Seymour, Mo.
(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 Oct Day 9
Year 1944 Hour _____ Minute _____ M.

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

that I last saw him/her _____, 19____;

and the death occurred on the date and hour stated above.

Immediate cause of death myocardial Duration _____Degeneration 3 yrs.

Due to _____

Due to _____

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

Due to _____

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

MOTHER FATHER

SUPPLEMENTARY

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 Dr. J. P. Hill (M. D. or other)Address Seymour, Mo. Date signed 12/10

S-42360 1944