

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1646

State File No. _____

FILED FEB 19 1945

Registration District No. _____

Primary Registration District No. 5108

Registrar's No. 1

1. PLACE OF DEATH:
Benton
 (a) County _____
 (b) City or town Cole Camp Rural Williamstownship
 (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 _____
5 Days (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Donna Maria Cain
 3. (b) If veteran, name war _____ 3. (c) Social Security No. No

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased January 25th 1945
 (Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 5
 If less than one day _____ hr. _____ min.

9. Birthplace Benton Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Walter Cain

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

14. Maiden name Hazel Parker

15. Birthplace Kansas City Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Hazel Cain

(b) Address Cole Camp Mo

17. (a) Burial (b) Date thereof Jan 31, 1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cole Camp Cemetery

18. (a) Signature of funeral director Edward L. Eickhoff
 (b) Address Cole Camp Mo

19. (a) FEBRUARY 3-45 (b) Pauline Harris
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Benton
 (c) City or town Cole Camp Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3 Miles East
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 30
 year 1945 hour 11 minute 50 AM.

21. I hereby certify that I attended the deceased from Jan 25
1945, to Jan 30 1945
 that I last saw her alive on Jan 30 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Brain Hemorrhage

Due to Congenital Debility
Septicemia

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____

Duration _____
 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)
 (a) Means of injury _____

23. Signature Byron L. Swain (M. D. or other) _____
 Address Cole Camp Mo Date signed 1-30-45

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

MOTHER FATHER

1341

1-45-124
2-13-45

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..... Edward L. Eickhoff

Licensed Embalmer No..... 780

P. O. Address..... Cole Camp, 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.