

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 20 1945

Registration District No. 47

Primary Registration District No. 308

Registrar's No. 411

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

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 yrs 4 mo 8 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME ARTIE MAHAN

3. (b) If veteran, name war DK

3. (c) Social Security No. DK

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive none years

7. Birth date of deceased _____
(Month) (Day) (Year) 1874

8. AGE: Years 70 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

12. Name _____

13. Birthplace Mo. Reeds A
(City, town, or county) (State or foreign country)

14. Maiden name Mo. Reeds A

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

16. (a) Informant Records State Hospital No. 1

(b) Address Fulton Mo

17. (a) Funeral (b) Date thereof Dec 19-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Grounds

18. (a) Signature of funeral director W. E. Thomas

(b) Address 302 Market St. Fulton Mo

19. (a) 12-18-1944 (b) Joan M. Mouskoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler 14

(c) City or town DK
(If outside city or town limits, write "RURAL") 2

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 17
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 11
year 1944 hour 3 minute 30 P M.

21. I hereby certify that I attended the deceased from Dec 11 to Dec 11, 1944
that I last saw him alive on Dec 11, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to _____

Due to 93%
10

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)

(e) Means of injury DK

23. Signature Walter Thomas (M. D. or other) MD

Address Fulton Mo Date signed 12/19/44

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 1-19-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.