

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

3707

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 12 1945

Registration District No. 392

Primary Registration District No. 4472 4471

Registrar's No. 45

1. PLACE OF DEATH

(a) County Saline

(b) City or town Gillian
(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 12 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline

(c) City or town Gillian 97
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country us

3. (a) PRINT FULL NAME Martha Helen Melan

3. (b) If veteran, ✓ name war _____

3. (c) Social Security No. —

4. Sex Female 5. Color or race White

(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 Aug 10 - 1854
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 10
year 1945 hour 10 minute 40 M. P

21. I hereby certify that I attended the deceased from Dec 4 to Dec 30, 1944
that I last saw him alive on Dec 30, 1944
and that death occurred on the date and hour stated above.

8. AGE: Years 90 Months 4 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace near State Saline Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name James Smith Guthrie

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

14. Maiden name Helen Temple Brown

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

16. (a) Informant Mrs. G. W. G. Medical

(b) Address Gillian, Mo.

17. (a) Burial (b) Date thereof 1-3-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Grove Mortuary

18. (a) Signature of funeral director John R. Lawrence
(b) Address State, Mo.

19. (a) Jan 9 - 45 (b) Mrs. John Giger
(Date received local registrar) (Registrar's signature)

Immediate cause of death.

Myocardial Infarction
Pulmonary Congestion

Due to Fracture of right hip

Due to _____

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 home ✓

(c) Where did injury occur? home (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) _____

(e) Means of injury ✓

Signature John R. Lawrence (M. D. or other) ✓

Address _____ Mo. Date signed Jan 5-45

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-10-45

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

working under my personal supervision.

Registered Apprentice No.

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.

Registration District No. 322

Primary Registration District No. 471

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Gallatin
(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 _____ (years, months or days)

3. (a) PRINT FULL NAME Martha H. Mahan

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 w

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

7. Birth date of deceased Aug 10 (Month) (Day) (Year)

8. AGE: Years 90 Months 4 Days _____ (less than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. 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 _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1960 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her 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)

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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) fall at home

(b) Date of occurrence _____

(c) Where did injury occur? Bilham, Ethie, Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home

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

23. Signature J. Lawrence (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

3707

John P Lawrence
Providence, R.I.