

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3916

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County North
(b) City or town Middlefork
(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 70 yrs
years, months or days

3. (a) PRINT FULL NAME George Washington Costin
3. (b) If veteran, ✓ name war _____
3. (c) Social Security No. ✓

4. Sex m 5. Color or race w
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 15 1861
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 2 If less than one day
hr. _____ min. _____

9. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Unknown

11. Industry or business _____

MOTHER FATHER { 12. Name Charles Costin
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Papas
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Paula Costin
(b) Address Grant City, Mo.

17. (a) Burial (b) Date thereof 1-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Smithton

18. (a) Signature of funeral director Arch E. Duffee

(b) Address Grant City, Mo.

19. (a) Jan. 20 1945 (b) Mayme Ruchart
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County North 113
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Grant City, Mo. 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 17
year 1945 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____,
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocarditis

Due to _____
Due to 93 E
Other conditions _____
(Include pregnancy within 3 months of death)

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) _____
(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)
(c) Means of injury B.O.

23. Signature Bentley Neal (M-Dr or other) B.O.
Address Grant City, Mo. Date signed 1-18-45

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.