

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

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAR 7 1945

Registration District No. 207

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4319

State File No.

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Marion Mo
(b) City or town Belle
(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 Emma Christiana Willoughby

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 _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April - 8 - 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 9 13 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Herman Enke

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

14. Maiden name Christiana Hansfield

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

16. (a) Informant Mrs Lizzie Shanks

(b) Address Belle Mo

17. (a) Burial (b) Date thereof 1-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Cemetery

18. (a) Signature of funeral director Clyde Mott

(b) Address Linn Mo

19. (a) 1/26/45 (b) Emma Bassett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion
(c) City or town Belle - 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 1 day 21
year 1945 hour Three minute A.M.

21. I hereby certify that I attended the deceased from 1/22/45 to 1/20/45
that I last saw her alive on 1/20/45, 19
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage Duration 10 hr.

Due to Arterio sclerosis - yes

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)

(2) Means of injury _____

23. Signature R. H. Schoenwald

Address Belle, Mo Date signed 1/24/45

MAR - 8 1945

RECEIVED

District Health Officer No. 9.

District File Number.....

Date Filed 3-6-45

MAR - 8 1945

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.....

Ames D. Jones Jr.
working under my personal supervision.

Registered Apprentice No. 373

Signed

Victor Buescher

Licensed Embalmer No. 3701

P. O. Address Jefferson City 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.