

FILED MAR 12 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7028

State File No.

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 318 319

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(c) Name of hospital or institution: Mo. State Hospital No. 4
(d) Length of stay: In hospital or institution 26 das.
In this community 26 years, months or days

2. USUAL RESIDENCE OF DECEASED:

Missouri
(a) State Missouri (b) County Scott
(c) City or town Diehlstadt
(d) Street No. 0
(e) Citizen of foreign country? No
If yes, name country 0

3. (a) PRINT FULL NAME EFFIE MAY MAYNARD

3. (b) If veteran, name war _____ 3. (c) Social Security No. 499-20-5885

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Finly Maynard 6. (c) Age of husband or wife if alive Age Unk.
7. Birth date of deceased March 9, 1902

8. AGE: Years 42 Months 11 Days 5 If less than one day hr. min.

9. Birthplace Fredericktown Missouri

10. Usual occupation Housewife and shoe factory worker

11. Industry or business _____

12. Name John Hightower
13. Birthplace Unknown
14. Maiden name Annie Hughes
15. Birthplace Unknown

16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 2-16-45
(c) Place; burial or cremation Diehlstadt, Missouri

18. (a) Signature of funeral director Nunnelee Undertakers
(b) Address Charleston, Missouri

19. (a) 2-16-45 (b) James Johnson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 14 year 1945 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from January 19, 1945 to Feb. 14, 1945

that I last saw her alive on Feb. 14, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death specific pneumonia not

Due to 10911

Due to _____

Other conditions same pneumonia
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy No 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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? _____ (e) Means of injury 0

23. Signature M. J. Johnson (M. D. or other) and
Address 10911 Date signed 2-15-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

004

1373

(Licensed Embalmer's Statement on Reverse Side) Farmington, Mo.

RECEIVED

District Health Officer No. 4
District File Number: 245-398
Date Filed: 3-9-45

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

Chase
Licensed Embalmer No. 4084

P. O. Address *Farmington 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.