

MISSOURI STATE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. 94

FILED APR 10 1945

Registration District No. Primary Registration District No. 3008

14
no 1

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

1. PLACE OF DEATH:

(a) County Galloway

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

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

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Audrain

(c) City or town Ladonia 111
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary Alice Eales

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 5. Color or race white

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 1916
(Month) (Day) (Year)

8. AGE: Years 85 Months Days If less than one day
hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Martha Kenner

(b) Address Ladonia Mo

17. (a) Burial (b) Date thereof Mar 17 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Geneter Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) 3-17-1945 (b) [Signature]
(Date required local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15
year 45 7 hour..... minute..... P. M.

21. I hereby certify that I attended the deceased from March 14, 1945, to March 15, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death.....
Bronch pneumonia

Due to Chronic myocarditis

Due to.....

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

Major findings:
Of operations..... [Signature]

Of autopsy.....

Duration

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)
(c) Means of injury.....

23. Signature Forrest Thomas (M. D. or other)
Address Julesburg Mo Date signed 3/15/45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed

4-9-45

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

Frank R. Hill

Licensed Embalmer No.

4206

P. O. Address

Center No

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.