

No. 2
9-4-41
5-17-39
X29484

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9293

State File No. _____

FILED MAR 22 1945
Registration District No. _____

Primary Registration District No. 3008

Registrar's No. 89

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Callaway

(c) Name of hospital or institution State #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-12-40
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Callaway

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

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

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Tillian E. Muckey

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 14
year 1945 hour 2 minute 0 P. M.

21. I hereby certify that I attended the deceased from 2-12-40 to 3-14-45
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color of race W

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan 1 1869
(Month) (Day) (Year)

Immediate cause of death chronic myocarditis

Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>2</u>	<u>7</u>	hr. _____ min. _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93d

9. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

10. Usual occupation _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Oliver Thompson

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

14. Maiden name Brookline Brown

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

16. (a) Informant Record

(b) Address _____

17. (a) Removal (b) Date thereof 3/14/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia, Mo

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? _____

18. (a) Signature of funeral director Hallace Funeral Home

(b) Address Tulton, Mo (D. G. Browning, mgr.)

19. (a) 3-14-1945 (b) Joie M. Schuff
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury _____

Signature H. E. Starnell (M. D. or other) _____

Address Tulton, Mo. _____

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 3-21-45

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 Renzil C. Browning

Licensed Embalmer No. 2724

P. O. Address: Fulton 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:

MAR 29 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 89

Registration District No. 47 Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(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 Lillian E Menckey

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 _____

7. Birth date of deceased Jan 1886
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation etc

11. Industry or business etc

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-14-1945 (b) Josie Morant Hoff
(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 Mar year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

9293