No. 2
8-43
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X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 19 1945

Registration District No. 382

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 9807

Primary Registration District No. 4228

Registrar's No. 11

**1. PLACE OF DEATH:**

(a) County HOWARD

(b) City or town GLASGOW
(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) 1

(d) Length of stay: In hospital or institution (Specify whether
In this community 4 months
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Howard

(c) City or town Glasgow 45
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? no 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME BARBARA ANN WHITE

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE 3

5. Color or race NEGRO

6. (a) Single, widowed, married, divorced Infant 0

6. (b) Name of husband or wife —

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

7. Birth date of deceased NOV (Month) 27 (Day) 1944 (Year)

8. AGE: Years — Months 4 Days — If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business —

FATHER
12. Name Richard White
13. Birthplace Glasgow (City, town, or county) Mo (State or foreign country) 0

MOTHER
14. Maiden name Clotile Ward
15. Birthplace Glasgow (City, town, or county) Mo (State or foreign country) 0

16. (a) Informant Lottie Biffs

(b) Address Glasgow Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Glasgow Mo

18. (a) Signature of funeral director Walker Audsley

(b) Address Glasgow Mo.

19. (a) 5/30/45 (Date received local registrar) (b) R. O. Rainey (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 27 year 1945 hour 10:00 minute A M.

21. I hereby certify that I attended the deceased from never, 19, to, 19; that I last saw h alive on, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Suffocation (asphyxiation)

Due to

Due to

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

Major findings:
Of operations

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 followings.

(a) Accident, suicide, or homicide (specify) accident 3-27-45

(b) Date of occurrence 3-27-45

(c) Where did injury occur? Glasgow (City or town) Howard (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home
(Specify type of place)

While at work? — (e) Means of injury —

23. Signature M Phleck MD (M. D. or other)

Address Fayette Mo Date signed 3-28-45

1419

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 8,
District File Number
Date Filed 4/9/45

STATEMENT BY LICENSED EMBALMER

This body was not embalmed

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 J. Walker Audsley

Licensed Embalmer No. 3336

P. O. Address Glasgow 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.**

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 382 Primary Registration District No. Registrar's No. 11

1. PLACE OF DEATH:
(a) County Howard
(b) City or town Glasgow
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Barbara A. White
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. 27 (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19, 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

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) accident
(b) Date of occurrence May 27, 1945
(c) Where did injury occur? Glasgow Howard Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home bed (Specify type of place)
While at work (e) Means of injury Suffocation
23. Signature M. Leach MD (M. D. or other)
Address Date signed 4-13-45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

182-2

9807