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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 3 1945

THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

10054

State File No.

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 23

**1. PLACE OF DEATH:**

(a) County Lawrence

(b) City or town Mt. Vernon, Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri State Sanatorium (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1308 days (Specify whether years, months or days)

In this community 1308 days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jefferson

(c) City or town Festus (If outside city or town limits, write "RURAL") 50

(d) Street No. 105 Chestnut (If rural, give location) 3

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

If yes, name country

3. (a) PRINT FULL NAME Florence Mabel Decker

3. (b) If veteran, name war X

3. (c) Social Security No. none

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Metford Decker

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Nov. (Month) 16 (Day) 1903 (Year)

8. AGE: Years 41 Months 3 Days 25 If less than one day hr. min.

9. Birthplace Desloge (City, town, or county) Missouri (State or foreign country) O

10. Usual occupation Housewife

11. Industry or business K

MOTHER FATHER

12. Name William Butler

13. Birthplace DeSoto (City, town, or county) Missouri (State or foreign country) O

14. Maiden name Rose Ann Henroid

15. Birthplace Valley Mines (City, town, or county) Missouri (State or foreign country) O

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State San. Mt. Vernon, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Mch 13 - 45 (Month) (Day) (Year)

(c) Place: burial or cremation Festus, Mo

18. (a) Signature of funeral director Geo B Orr

(b) Address Mt Vernon Mo

19. (a) 3-14-45 (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 13th year 1945 hour 3:20 minute A M.

21. I hereby certify that I attended the deceased from Aug. 13, 1941 to March 13, 1945; that I last saw her alive on March 12, 1945; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Toxic Nephritis (Chronic)

Due to Pulmonary tbc Over 6 yrs

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)

(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? (Specify type of place)

While at work? (e) Means of injury O

23. Signature Charles A. Brasby (M. D. or other) M.D.

Address 3-13-45 Date signed Mt. Vernon Mo

1338 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 445-383
Date Filed APR 2 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed: George B. Ow

Licensed Embalmer No. 946

P. O. Address Mt Vernon M

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

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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. 383 Primary Registration District No. 5655 Registrar's No. 30

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Mt Vernon Twp
(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 Florence M. Decker
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. 16 1903 (Month) (Day) (Year)
8. AGE: Years 41 Months 3 Days 25 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (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) 3-19-45 (Date received local registrar) (b) Cecil Crawford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 13 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 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 | 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)
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

10054