

S. No. 2  
FORM-2-43  
Rev. 5-17-39  
X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10813  
Registrar's No. 88

FILED APR 26 1945  
Registration District No. 4519

Primary Registration District No. 4519

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

1. PLACE OF DEATH:  
(a) County Texas  
(b) City or town Cabool  
(c) Name of hospital or institution: west part of town  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 yrs  
In this community 17 yrs  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. (b) County Texas  
(c) City or town Cabool  
(If outside city or town limits, write "RURAL") 107  
(d) Street No. 1  
(If rural, give location) 1  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME LEATHA ISABEL ARCHER  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 26  
year 1945 1 hour 20 minute 0 A.M.  
21. I hereby certify that I attended the deceased from March 25 1945, to March 20 1945.  
that I last saw her alive on March 20 1945.  
and that death occurred on the date and hour stated above.

4. Sex F. 5. Color or race W  
6. (a) Single, widowed, married, divorced, Widowed  
6. (c) Age of husband or wife if alive 6 years  
7. Birth date of deceased Dec 1866  
(Month) (Day) (Year)

Immediate cause of death Chingina Pectoris  
Duration 24 hrs

8. AGE: Years 78 Months 3 Days 20  
If less than one day hr. min.

Due to.....  
Due to.....  
Other conditions (Includes pregnancy within 3 months of death).....  
Major findings: Of operations.....  
Of autopsy.....

9. Birthplace Ark. 1  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

11. Industry or business.....  
12. Name William Coate  
13. Birthplace.....  
14. Maiden name Rebecca Williams  
15. Birthplace.....

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

16. (a) Informant: Joel Archer  
(b) Address: Cabool Mo.  
17. (a) Burial (b) Date thereof Mar. 28-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Jarrett Cemetery  
18. (a) Signature of funeral director Raymond V. Elliott  
(b) Address: Cabool Mo.  
19. (a) Mar. 28-45 (b) Mrs. Lois Miller  
(Date received local registrar) (Registrar's signature)

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 0  
23. Signature J.W. Coate (M. D. or other) 0  
Address Cabool Mo. Date March 27 1945

RECEIVED

District Health Officer No. 5,

District File Number

445165

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

*Gaylord Elliott*

Licensed Embalmer No. 2252

P. O. Address Cabool 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.