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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12674

Registration District No. 1 Primary Registration District No. 4012 Registrar's No. —

1. PLACE OF DEATH:
(a) County ATCHISON
(b) City or town ROCK PORT (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 (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)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County ATCHISON 3
(c) City or town ROCK PORT 1 (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME LIBBY SUSAN MASSINGILL
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 MARRIED
6. (b) Name of husband or wife WM MASSINGILL 6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased 12 (Month) 6 (Day) 1872 (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	3	25	hr. min.

9. Birthplace RONCEVERTE, W. VA. 1 (City, town, or county) (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business
FATHER 12. Name R.F ERWIN
13. Birthplace UNKNOWN W. VA. 1 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name ANNA MARY BURDETTE
15. Birthplace UNKNOWN W. VA. 1 (City, town, or county) (State or foreign country)
16. (a) Informant Wm. Massingill
(b) Address Rock Port Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-3-45 (Month) (Day) (Year)
(c) Place: burial or cremation ENGLISH GROVE
18. (a) Signature of funeral director Bartholomew Mortuary
(b) Address Rock Port Mo
19. (a) April 3 1945 (Date received local registrar) (b) Mrs Herbert Townsend (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 1 year 1945 hour 4 minute ✓ A.M.
21. I hereby certify that I attended the deceased from Jan 1 - 45, 19__, to March 28, 1945 that I last saw h__ alive on March 27, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	2 wks
Due to	
Due to	
Other conditions none (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy none	

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 Cleo Vaugh (M.D. or other)
Address Tarkio Mo Date signed 4-2-45

1335 (Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 3173

P. O. Address Rock Port 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.