

V. S. No. 2
FORM—9-4-41
Rev. 5-17-39
i X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16505**
Registrar's No. **132**

FILED JUN 9 1945

Registration District No. **47**

Primary Registration District No. **3008**

14
2

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton

(c) Name of hospital or institution State Hospital # 1 2
(If outside city or town limits, write "RURAL" and name of township)

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

In this community _____ years, months or days

3. (a) PRINT FULL NAME Jesse Spears

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race neg 6. (a) Single, widowed, married, divorced 9 divorced

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 70? 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 OTC

MOTHER FATHER { 12. Name OTC

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

14. Maiden name OTC

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

16. (a) Informant Beckwith Flat (b) Address Fulton mo

17. (a) Burial (b) Date thereof May 8, 45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of general director Eli Bell

(b) Address Fulton mo

19. (a) 5-6-1945 (b) Jessie M. ... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Jackson

(c) City or town Kansas City 14 (If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 2 year 1945 hour 9 minute a M.

21. I hereby certify that I attended the deceased from 11-19-1940 to 5-1-1945

that I last saw him alive on 5-1-1945 and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid hemorrhage

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 12/1

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 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 K. E. Sherrill (Physician's signature)

Address Fulton mo Date signed 5/2/45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed

6-7-45

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

Eli Bell

Licensed Embalmer No.

2130

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.