

S. No. 2  
DOM-2-43  
v. 5-17-39  
I X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16715

State File No. \_\_\_\_\_

**FILED MAY 31 1945**

Registration District No. 74

Primary Registration District No. 5343

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dade

(b) City or town Arcola North town  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Arcola !  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No (Specify whether years, months or days)

In this community 63 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade 29

(c) City or town Arcola 0  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? ✓ 11 (Yes or No)  
If yes, name country ✓

3. (a) PRINT FULL NAME FRANCES C. TWADDELL

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month May day 7  
year 1945 hour 7 minute 30 A. M.

3. (b) If veteran, name war No

3. (c) Social Security No. No

21. I hereby certify that I attended the deceased from Feb 27, 1945, to May 7, 1945, that I last saw her alive on April 23, 1945 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (c) Age of husband or wife if alive 24 years (Day) (Year)

7. Birth date of deceased February (Month) 24 (Day) 1872 (Year)

Immediate cause of death Intestinal obstruction

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>2</u>	<u>13</u>	hr. min.

Due to Ca. of sigmoid colon

Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Home

Major findings: Of operations None

11. Industry or business Home

Of autopsy \_\_\_\_\_

12. Name John C. Woods

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

13. Birthplace No Record 4  
(City, town, or county) (State or foreign country)

14. Maiden name Marie Slusher

15. Birthplace No Record 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Lloyd Twaddell

(b) Address Arcola Mo

17. (a) Burial (b) Date thereof 5/9/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenfield Cemetery

18. (a) Signature of funeral director Samuel S. Sweeney

(b) Address Greenfield Mo

19. (a) 5-15-45 (b) W. C. Kirby  
(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 \_\_\_\_\_

23. Signature W. C. Kirby (M. D. or other) W. C.

Address Greenfield Date signed 5-8-45

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

9  
0  
0

1843

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
District Health Officer No. 6.  
District File Number 545-619  
Date Filed MAY 28 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 *Sam E. Sweeney Jr.*

Licensed Embalmer No. *4099*

P. O. Address *Greenfield 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.