S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 11 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17153

Registration District No. 155 — Primary Registration District No. 4244 — Registrar's No. 9

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carterville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 215 N. Fountain
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 46 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
(c) City or town Oronogo
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - -

3. (a) PRINT FULL NAME Ida Elizabeth Althouse

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Ed Althouse

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

7. Birth date of deceased September (Month) 23 (Day) 1868 (Year)

8. AGE: Years 76 | Months 8 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace St. Paul (City, town, or county) Kansas (State or foreign country)

10. Usual occupation At Home

11. Industry or business None

FATHER
12. Name - - - Sylvester
13. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Sarah Railsback
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs. Bertha Allen
(b) Address Oronogo, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Oronogo Cemetery

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Missouri

19. (a) May 29 1945 (Date received local registrar) (b) Mrs. Lillie Lagle (Registrar's signature)

1150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26 year 1945 hour 7 minute 05 P. M.

21. I hereby certify that I attended the deceased from Jan. 7, 1945, to May 26, 1945; that I last saw her alive on May 26, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to .....

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

Major findings:
Of operations .....
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? .....
(Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature P. M. Pence (M. D. or other) D.O.
Address Carterville, Mo. Date signed 5/28/45

(Licensed Embalmer's Statement on Reverse Side)

45-5-432

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 Lucy Kuell-Buckwell

Licensed Embalmer No. 2510

P. O. Address Carthage, 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.