

No. 43
17-39
X3667

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17880**
Registrar's No. **91**

Registration District No. **279**
Primary Registration District No. **3056**

1. PLACE OF DEATH:
(a) County **RANDOLPH**
(b) City or town **MOBERLY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
McCORMICK HOSP. 13
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 Mo - 13 DA**
(Specify whether
In this community **6**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **MONROE**
(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")
(d) Street No. **7 MI. N. OF MADISON**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **✓**

3. (a) PRINT FULL NAME **FANNIE BEAN**
3. (b) If veteran, **✓** name war **✓**
3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **may** day **11**
year **1945** hour **2** minute **20 P. M.**
21. I hereby certify that I attended the deceased from **Nov. 28**
1944 to **may 11**, 19**45**
that I last saw her alive on **May 11**, 19**45**
and that death occurred on the date and hour stated above.

4. Sex **FEMALE**
5. Color or race **WHITE**
6. (a) **2** **WIDOWED**
Single, widowed, married, divorced, or never married
6. (b) Name of husband or wife **OSCAR BEAN**
6. (c) Age of husband or wife if alive **4** years
7. Birth date of deceased **1863**
(Month) (Day) (Year)

Immediate cause of death:
Hemorrhage into brain **3 days**
Due to **Fracture of hip** **6 1/2 months**
Due to _____

8. AGE: Years **82** Months _____ Days _____
If less than one day hr. _____ min. _____

Other conditions (Include pregnancy within 3 months of death) **ALL SUPPLEMENTARY INFORMATION REQUESTED**
Major findings: Of operations _____
Of autopsy _____

9. Birthplace **MONROE Co. Mo. 11**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**
11. Industry or business **✓**
12. Name **THOS HAXDEN**
13. Birthplace **KY 1**
(City, town, or county) (State or foreign country)
14. Maiden name **FRANCIS WRIGHT**
15. Birthplace **KY 1**
(City, town, or county) (State or foreign country)

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? **✓**

16. (a) Informant **Paul Haxden**
(b) Address **MOBERLY MO**
17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **5-15-45**
(Month) (Day) (Year)
(c) Place: burial or cremation **OAK GROVE, MONROE CO.**

While at work? **✓** (Specify type of place)
(e) Means of injury **✓**
23. Signature **G. L. McCormick** (M. D. or other) **MD**
Address **moberly mo** Date signed **5-11-45**

18. (a) Signature of funeral director **Speed & Blaney**
(b) Address **PARIS MO**
19. (a) **5-14-45** (Date received local registrar)
(b) **Erma Nave** (Registrar's signature)

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

1036

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 10

District File Number 6-45-978

Date Filed JUN 12 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 W. G. Blakey
Licensed Embalmer No. 2614
P. O. Address PARIS, 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.

Registration District No. 294

Primary Registration District No. 3056

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

3. (a) PRINT FULL NAME Fannie Bean

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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 82 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1944 hour _____ minute _____ M. _____
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy 1860 17

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence Nov. 28 - 1944
(c) Where did injury occur? woodlawn Randolph mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home
While at work _____ (Specify type of place) (e) Means of injury Fell
23. Signature F. P. Mc Cormick (M. D. or other) MD
Address _____ Date signed 6-15-45

SUPPLEMENTARY

WRITE PLAINLY - USING BLACK INK - MAKE A PERMANENT RECORD

MOTHER FATHER

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

17880