

No. 2  
8-43  
17-39  
X37823

FILED JUN 13 1945

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

Registration District No. 224

Primary Registration District No. 1007

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

1. PLACE OF DEATH: Russell  
 (a) County Russell  
 (b) City or town Rural  
 (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 Macon  
 (c) City or town rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? 1 (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma Whitehead  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband William Whitehead 6. (c) Age of husband or wife if alive 89 years  
 7. Birth date of deceased June 12 1859  
 (Month) (Day) (Year)

8. AGE: Yes 85 Months 10 Days 21 If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired House wife

11. Industry or business \_\_\_\_\_

12. Name George Nisbeth

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

14. Maiden name Morah Beart

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

16. (a) Informant W.O. McQuary

(b) Address Quincy Ill

17. (a) Buried (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty

18. (a) Signature of funeral director Stephen Goodding

(b) Address Macon, Mo

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

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3rd  
 year 1945 hour 10 minute 0 P.M.  
 21. I hereby certify that I attended the deceased from April 15 1945 to May 3 1945  
 that I last saw him alive on May 3 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Branch pneumonia Duration 5 days  
 Due to Fractured hip 10 days  
 Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
 23. Signature C. A. Steynski (M. D. or other)  
 Address Jacksonville Mo Date signed May 30

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

STAR 1945 JUN 22

RECEIVED  
District Officer No. 10  
District File Number 6-45-966  
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  
working under my personal supervision.

Registered Apprentice No.  
Signed *C. L. Stephens*  
Licensed Embalmer No. 3057  
P. O. Address *Macon, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Randolph  
(b) City or town Rural  
(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  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Emma Whitehead  
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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased June 12 (Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name George Nisbeth

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

14. Maiden name Marrah 15. Birthplace England (City, town, or county) (State or foreign country)

16. (a) Informant W. O. McArthur (b) Address Ames, Mo.

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation Liberty

18. (a) Signature of funeral director Stephen Godding (b) Address Macan, Mo.

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Macan  
(c) City or town Rural (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 June Day 22 Year 1945 Hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Fracture Hip Duration 5 days

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

Due to Fracture Hip 10 days

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy 1860 17  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
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) Accident

(b) Date of occurrence Feb 22, 1945

(c) Where did injury occur? Jacksonville Randolph Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, or public place? In home arising from fall (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature C. A. Stuyjewski (M. D. or other) D.O. Address Jacksonville Mo. Date signed June 14, 1945

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

STUPID

EMMENTARY

17901

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17901  
Registrar's No. \_\_\_\_\_

Registration District No. (294) Primary Registration District No. (6007)

1. PLACE OF DEATH:

(a) County Randolph  
(b) City or town Bureau Jackson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Jacksonville Mo RED#2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: Months In hospital or institution (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Macon  
(c) City or town Tunas  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Emma W Hitchhead

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 m

6. (b) Name of husband or wife Wm 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased June 12 1884  
(Month) (Day) (Year)

8. AGE: Years 85 Months \_\_\_\_\_ Day \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name George Mabeth

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

14. Maiden name Marian Carter

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

16. (a) Informant W. O. McQuahy

(b) Address Amey Pl

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof Liberty (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Stephen A Gooding

(b) Address Mo can Mo

19. (a) \_\_\_\_\_ (Date received local registrar) (b) Irma Kavel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 3 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumoniae Duration 5 day

Due to Fracture Hip 10 day

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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

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 C. A Stysemeyer (M.D. or other)

Address Jacksonville Mo Date signed 9-20-45

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

**SUPERSEDED**

