

No. 1
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 19 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20441**

Registration District No. **140**

Primary Registration District No. **8024 5347**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Howard**

(b) City or town **Rural Mountain top**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
highway 40 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: **1** hospital or institution. (Specify whether years, months or days) **1 da.**

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Montgomery**

(c) City or town **Montgomery City, Mo**
(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 **Ruth Julia Compton**

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** - (26) day **26** of year **1945** hour _____ minute **2** p.m.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him **Dead** alive on _____ 19____ 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**

(b) Name of husband or wife **Perry Compton** 6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **Jan 21 1904**
(Month) (Day) (Year)

Immediate cause of death **fracture of skull** Duration _____

Due to **injury**

8. AGE: Years **41** Months **4** Days **5** If less than one day _____ hr. _____ min.

Due to _____

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

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED**

Of operations _____

Of autopsy _____

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

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

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **M. Oyer**

13. Birthplace **Wentzville Mo** (City, town, or county) (State or foreign country)

14. Maiden name **Mary P. Oyer**

15. Birthplace **Wentzville Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **Perry Compton**

(b) Address **Montgomery City Mo**

17. (a) Removal (b) Date thereof **July 26 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accident 045**

(b) Date of occurrence **5-26-45**

(c) Where did injury occur? **Howard County Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(c) Place: burial or cremation **Mounty view city limit**

18. (a) Signature of funeral director **Stegner, A. Benig**

(b) Address **Boonville Mo**

19. (a) 5-26-1945 (b) **Conrad Walker**
(Date received by Registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury **Auto crash**

23. Signature **W. A. Blom** (M. D. or other) **3**

Address **Fayette Mo** Date signed **5-26-45**

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

MOTHER FATHER

JUN 22 1945

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6/15/45

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 James W. Stegner
Licensed Embalmer No. 3780

P. O. Address Boonville, 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. July
Registrar's No. _____

Registration District No. 140 Primary Registration District No. 5547

1. PLACE OF DEATH:
(a) County Lauraud
(b) City or town Rural Monticary
(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 Ruth J. Compton
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 _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Jan 2 1894 (Month) (Day) (Year)

8. AGE: Years 41 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (Registrar's signature)
(Date received local registrar)

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 July Year 1948 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 immediately before death.

SUPPLEMENTAL
Fracture of skull with severe concussion of Brain
Due to Fire blowout causing car to turn over. State Highway #40
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) Accident
(b) Date of occurrence May 26 - 1948
(c) Where did injury occur? Howard County Mo.
(d) Did injury occur in or about some place, in industrial plant, in public place?

While at work? _____ (Specify type of place) (c) Means of injury Car wreck

23. Signature W. S. Bloom (M. D. or other) M.D.
Date signed July 20

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

S-20441