No. 2
—8-43
-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20800

Registration District No. 196 Primary Registration District No. 5716 Registrar's No. 5

1. PLACE OF DEATH:

(a) County McDonald Elmriver Twp

(b) City or town Noel 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 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County McDonald

(c) City or town Noel 60
(If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME Marinda Redfern

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

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fred Redfern 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Sept (Month) 10 (Day) 1867 (Year)

8. AGE: Years 77 Months 8 Days 28 If less than one day ____ hr. ____ min.

9. Birthplace McDonald Co (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation House wife

11. Industry or business Own Home

FATHER
12. Name Henry Gaunt
13. Birthplace unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Mollie Medows
15. Birthplace unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Fred Redfern 1
(b) Address Noel Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10-45 (Month) (Day) (Year)
(c) Place: burial or cremation Noel Mo

18. (a) Signature of funeral director E. R. Tyrott
(b) Address Gravette Ark.

19. (a) June 9-1945 (Date received local registrar) (b) Mrs E M George (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 8
year 1945 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from Aug, 1944, to June 8, 1945
that I last saw her alive on June 8, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	June 7
Due to myocarditis	
Nephritis	
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? ____ (e) Means of injury ____

23. Signature S. D. Tountain 2 (M.D. or other) DO

Address Noel Mo Date signed June 9, 45

1309 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 743-748
Date Filed JUL 9 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 E R Pyeatt

Licensed Embalmer No. 3211

P. O. Address Gravette Ark.

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.

No. 2B
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July 15

Registration District No. 196 Primary Registration District No. 5716 Registrar's No.

1. PLACE OF DEATH:
(a) County McDonald
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Marinda Redfern
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 Sept 10 1866 (Month) (Day) (Year)
8. AGE: Years 77 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 15 year 1946 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to chronic nephritis
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

NATIONAL VITAL STATISTICS SUPPLEMENTARY INFORMATION REQUESTED

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20800