

S. No. 27
DOM-2-43
ev. 5-17-39
I X35697

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21569**

FILED *Al 14 1945*

Primary Registration District No. **4529**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County *Vernon*

(b) City or town *Metz*
(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 *Five years*
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town *Metz*
(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 *Adda Mathie Palagoue*

3. (b) If veteran, name war: *✓*

3. (c) Social Security No. *✓*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *15* year *1945* hour *9* minute *45 AM*

21. I hereby certify that I attended the deceased from *October 10 1943* to *Feb 14 1944*
that I last saw him *or* alive on *Feb 14 1944*
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, widowed

6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: *June 24 1876*
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<i>68</i>	<i>11</i>	<i>22</i>	hr. min.

Immediate cause of death: *Cerebral Apoplexy*
Hypertensive C.V. Disease

Due to: *Cerebral Apoplexy Nov 1943*

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

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

10. Usual occupation *Homekeeper*

11. Industry or business _____

MOTHER FATHER

12. Name *John Richardson*

13. Birthplace *Unknown New York*
(City, town or county) (State or foreign country)

14. Maiden name *Melinda E. Knaples*

15. Birthplace *Harrisburg Penn.*
(City, town, or county) (State or foreign country)

16. (a) Informant *Mrs. Birdie Morrison*

(b) Address *Metz Mo.*

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

(c) Place: burial or cremation *Ball Town Cemetery*

18. (a) Signature of funeral director *Allen & Sons*

(b) Address *Nevada Springs*

19. (a) *June 26 1945* *Merle W. Charles*
(Date received local registrar) (Registrar's signature)

Major findings: *gsw*

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. Signatur *W. M. Allen* (M.D. or other) *MS.*

Address *Nevada Mo.* Date signed *6-18-45*

Duration *3 yrs*

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7

District File Number 6-43-695

District File

Date Filed 7-13-45

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 *H. H. Marmaduke*
Licensed Embalmer No. *2070*
P. O. Address *Woodley 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.