DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23236

FILED JUL 26 1945

Registration District No. 68 Primary Registration District No. 5-2-6-6 4119 Registrar's No. 12

1. PLACE OF DEATH:
(a) County: Christian
(b) City or town: Ozark
(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: 6 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Christian
(c) City or town: Clever
(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: Margaret Samuels
3. (b) If veteran, name war: X
3. (c) Social Security No.: none
4. Sex: female
5. Color or race: white
6. (a) Single, widowed, married, divorced: widow
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: unknown (Month) (Day) (Year)
family record destroyed by fire.

8. AGE: Years ? 63 Months ..... Days ..... If less than one day ..... hr. ..... min.

9. Birthplace: Mo (City, town, or county) (State or foreign country)
10. Usual occupation: housewife
11. Industry or business .....
MOTHER FATHER
12. Name: Bent Davis
13. Birthplace: Tenn / (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Janie Williams
15. Birthplace: Tenn / (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Myrtle Pope
(b) Address: Clever, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: June 25, 45 (Month) (Day) (Year)
(c) Place: burial or cremation: Wise Hill cemetry
18. (a) Signature of funeral director: T.W. Maples
(b) Address: Clever, Mo.
19. (a) July 3 '45 (Date received by local registrar) (b) Mabel Mapes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1945 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from July, 1944, to June 23, 1945 that I last saw h alive on June, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pernicious Anemia and Nephritis	
Due to	
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: J. H. Hall (M. D. or other)
Address: Joplin Mo. Date signed 6-27-45

1361

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 8
District File Number 743-803
Date Filed JUL 24 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 J W Mapler

Licensed Embalmer No. 2985

P. O. Address Clever Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2 [illegible]

. No. 2B
M—3-45
I 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. 23736

Registration District No. 68 Primary Registration District No. 4119 Registrar's No. 12

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Christian

(b) City or town Ozark
(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)

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 Margaret Samuels

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 Unk (Month) (Day) (Year)

8. AGE: Years 63 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

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

MOTHER
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 June day 25
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from June, 1945, to June 25, 1945
that I last saw him alive on June 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

131

Duration

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 J H Nade (M. D. ~~or other~~)

Address Ozark Mo Date signed