

235.2
-8-43
5-17-39
X37823

FILED AUG 14 1945

Primary Registration District No. 4322

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Mercer
(b) City or town Princeton
(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 all his life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mercer 6.5
(c) City or town Princeton (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 Marion Constable

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased Oct 15 1931
(Month) (Day) (Year)

8. AGE: Years 13 Months 9 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Low Constable

13. Birthplace Mercer Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Naomi Elmer

15. Birthplace Mercer Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Low Constable

(b) Address 922 Felix St Joseph Mo

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

(c) Place: burial or cremation Princeton Mo

18. (a) Signature of funeral director W. H. Moss

(b) Address Princeton Mo

19. (a) 7-28-45 (b) Leon Martin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1945 hour 2 minute p M.

21. I hereby certify that I attended the deceased from July 24 1945 to July 24 1945;

that I last saw h. not at all and that death occurred on the date and hour stated above.

Immediate cause of death Accidental death from Drowning

Due to _____

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) Accidental

(b) Date of occurrence July 24, 1945

(c) Where did injury occur? Princeton, Mercer, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Grand River
(Specify type of place) (e) Means of injury _____

23. Signature O. J. Bristow (M. D. or other) MD

Address Princeton, Mo Date signed 7/27/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1367

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 *M*

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Paul Moss*

Licensed Embalmer No. *2634*

P. O. Address *Pennington TN*

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. _____

Registrar's No. _____

LED AUG 14 1945

Registration District No. (210)

Primary Registration District No. (4322)

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

1. PLACE OF DEATH:

(a) County Merced
(b) City or town Marion
(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 Marion Constable

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased Oct 15 (Month) (Day) (Year)

8. AGE: Years 13 Months 9 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Data 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 _____ day _____ year _____ 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. Immediate cause of death _____

Due to _____

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 _____ (M. D. or other) _____

Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-24475