

No. 2
8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28275

Registration District No. 297

Primary Registration District No. 6021

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Ray 11
(b) City or town Grape Grove ms
(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 Geneva Rosetta Rhea

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

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 July 22 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 0 15 hr. min.

9. Birthplace Ray County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Alexander Smith

13. Birthplace Salene County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Susan C. Mays

15. Birthplace Unknown ""
(City, town, or county) (State or foreign country)

16. (a) Informant Joe Henderson

(b) Address Cowgill, Missouri.

17. (a) Burial (b) Date thereof 8--8-1945.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cowgill Cemetery

18. (a) Signature of funeral director: Cramer Clark

(b) Address Kingston, Missouri.

19. (a) Aug 14 1945 (b) Mrs. Shus W. Shppard
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 89
(c) City or town _____
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th
year 1945 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec, 1944, to Aug 6, 1945.
that I last saw him alive on Aug 7, 1945.
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Duration ?

Due to _____
Due to _____

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

Major findings: and
Of operations _____
Of autopsy none

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 Geo. S. Dowell (M. D. or other)
Address Raymer Mo. Date signed Aug 8-45

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

1280

RECEIVED

State Health Officer No. 8

Case File Number

Date Filed

9-11-45

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 Cramer Clark

Licensed Embalmer No. 3257

P. O. Address. KINGSTON, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Sept7Registration District No. 297Primary Registration District No. 6021Registrar's No. 7

1. PLACE OF DEATH

(a) County Ray
(b) City or town Shreve Grove Ind.
(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

Genevieve Rhea

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 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 _____

7. Birth date of deceased July 22 1945
(Month) (Day) (Year)8. AGE: Years 76 Months _____ 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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____18. (a) Signature of funeral director _____
(b) Address _____19. (a) _____ (b) Mrs. Chas W Sheppard
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town Cowgill, Mo RURAL
(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 Dec year 1945 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her 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 _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

S-28275

OCT 25 1946

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