

S. No. 2
E-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28789
Registrar's No. 39

Registration District No. 366

Primary Registration District No. 45-35-

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

1. PLACE OF DEATH:
 (a) County WASHINGTON
 (b) City or town MINERAL POINT MO.
 (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 87-4-5 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County WASHINGTON
 (c) City or town MINERAL POINT MO.
 (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 MARY ROSIE DEAN
 (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED
 (b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased MARCH 20 - 1858
 (Month) (Day) (Year)

8. AGE: Years 87 Months 4 Days 5
 If less than one day _____ hr. _____ min.

9. Birthplace OLD MINES MO.
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name JOSEPH TROKEY
 13. Birthplace OLD MINES MO.
 (City, town, or county) (State or foreign country)
 14. Maiden name UNKNOWN
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant J.A. COURTOIS
 (b) Address MINERAL POINT MO.

17. (a) BURIAL (b) Date thereof 7-27-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OLD MINES MO
 18. (a) Signature of funeral director Boyer Funeral Home

(b) Address P. O. 7051 MO.

19. (a) 7-26-45 (b) Jos. L. Thurman
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 7 day 25
 year 1945 hour 8 minute 0 A.M.
 21. I hereby certify that I attended the deceased from 3-2
1945 to 7-25 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:
 Of operations _____
 Of autopsy 930
 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 Jos. L. Thurman (M. D. or other) _____
 Address Patton, Mo. Date signed 7-26-45

RECEIVED

State Health Officer No. 4
District File Number 945-1030
Date Filed 9-5-45

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 _____

Licensed Embalmer No. 4158

P. O. Address 707051 210

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.