U. S. No. 2
DM—8-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28816

Registration District No. 379 Primary Registration District No. 6287 Registrar's No. 12

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1. PLACE OF DEATH:
(a) County Wright
(b) City or town Pleasant Valley Twp - Rural
(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
In this community 79 yrs 6 mo. - 7 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Wright 114
(c) City or town Pleasant Valley Twp - Rural 0 0
(If outside city or town limits, write "RURAL")
(d) Street No. 3 miles North of Mansfield Mo 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Triffie Catharine Hight
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife William H Hight
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 21 (Day) 1866 (Year)

8. AGE: Years 79 Months 6 Days 7 If less than one day hr. min.

9. Birthplace Mansfield (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Jack Turner
13. Birthplace Tenn. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Not Known
15. Birthplace Not Known (City, town, or county) (State or foreign country)
16. (a) Informant Homer Hight
(b) Address Mansfield Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Turner Cemetery
18. (a) Signature of funeral director [illegible] Staffa
(b) Address Mansfield Mo.
19. (a) Aug 31 1945 (Date received local registrar) (b) S. L. Henaly (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28 year 1945 hour 10 minute 20 P. M.
21. I hereby certify that I attended the deceased from 10-20-44 to 8-28 1945; that I last saw her alive on 8-28 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Nephritis	10 yr
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. A. Frison (M. D. or other)
Address Mansfield Mo Date signed 8-30-45

1267 (Licensed Embalmer's Statement on Reverse Side)

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 F. G. Steffen

Licensed Embalmer No. 3221

P.O. Address Mansfield 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.