S. No. 2
M—8-43
5-17-39
P I X37823

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. Baker 30090

FILED OCT 6 1945

Registration District No. 37 Primary Registration District No. 5-F-F-9 4049 Registrar's No. 1

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Centralia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ✓ 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 79 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10
(c) City or town Centralia 1
(If outside city or town limits, write "RURAL")
(d) Street No. S. Lease 0
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ida May Naylor
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex f 1
5. Color or race W
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife Geo P. Naylor
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased 5 (Month) 12 (Day) 1866 (Year)

8. AGE: Years	Months	Days	If less than one day
79	4	12	hr. min.

9. Birthplace Hallsville Mo. 0
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business ✓
FATHER
12. Name John Jones 1
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Elizabeth Perry
15. Birthplace Boone Co Mo. 1
(City, town, or county) (State or foreign country)
16. (a) Informant John C Naylor
(b) Address St Louis Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Centralia Mo Cem
18. (a) Signature of funeral director [illegible]
(b) Address Centralia Mo
19. (a) 9/26-1945 (Date received local registrar) (b) Lizzie Estepp (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24 year 1945 hour 9 minute 30 P M.
21. I hereby certify that I attended the deceased from 2-25-43, 19__, to 9-24-45, 19__; that I last saw her alive on 9-24-45, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertension and arteriosclerosis	
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 P. O. Baker D.D. (M. D. or other)
Address Centralia Mo Date signed 9-25-45

1597 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number.....
Date Filed 10-5-45

OCT 19 1945

OCT 22 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 M. McDonald

Licensed Embalmer No. 4313

P. O. Address Centralia 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.

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STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 37 Primary Registration District No. (5119) 4049 Registrar's No. .....

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Centralia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Centralia Missouri
(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 Mo (b) County Boone

(c) City or town Centralia
(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 Ida May Naylor

3. (b) If veteran, name war no

3. (c) Social Security No. none

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 May (Month) 12 (Day) 1864 (Year)

8. AGE: Years 79 Months 4 Days 12 If less than one day ..... hr. ..... min.

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

10. Usual occupation None

11. Industry or business .....

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

MOTHER
14. Maiden name Elizabeth Berry
15. Birthplace Boone Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant John Naylor
(b) Address St Louis Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (Month) 26 (Day) 45 (Year)
(c) Place: burial or cremation Centralia Mo

18. (a) Signature of funeral director M McKinnon
(b) Address Centralia Mo

19. (a) ..... (Date received local registrar) (b) Lizzie Estippe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24 year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw h..... alive on ....., 19...; and that death occurred on the date and hour stated above.

	Duration
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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

30090