

S. No. 2
OM-5-43
ev. 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. **31045**

FILED OCT 4 1945
Registration District No. **233**

Primary Registration District No. **4348**

Registrar's No. **1**

70
20
0
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Madison**

(b) City or town **Wellsville 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 **7 year** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Madison**

(c) City or town **Wellsville Mo** **2**
(If outside city or town limits, write "RURAL")

(d) Street No. **1** **0**
(If rural, give location)

(e) Citizen of foreign country? **—** **0** (Yes or No)
If yes, name country **—**

3. (a) PRINT FULL NAME **Louise Catherine Sheets**

3. (b) If veteran, name war **—**

3. (c) Social Security No. **2**

MEDICAL CERTIFICATION

25. DATE OF DEATH: Month **Sept** day **2** year **1945** hour **2 a.m.** minute **—** M.

21. I hereby certify that I attended the deceased from **Aug 18 -** 19 **45** to **Sept 2 -** 19 **45** and that death occurred on the date and hour **Sept 2** **1st** 19 **45**.

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Joseph S. Sheets**

6. (c) Age of husband or wife if alive **—** years

7. Birth date of deceased **Aug 24 1859**
(Month) (Day) (Year)

Immediate cause of death **Coronary atherosclerosis**

Due to **hypertension + chronic bronchitis**

8. AGE: Years **85** Months **08** Days **08** If less than one day hr. **—** min. **—**

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

10. Usual occupation **House Wife**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **None**

Autopsy **—**

PHYSICIAN **—**
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry of business **Same as above**

12. Name **Wm Jackson Madgett**

13. Birthplace **Wellsville Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Madgett**

15. Birthplace **Wellsville Mo**
(City, town, or county) (State or foreign country)

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 **R. G. Hinesford** (M. D. or other) **—**
Address **Wellsville Mo** Date signed **Sept 2 1945**

16. (a) Informant **Paul Sheets**

(b) Address **Wellsville Mo**

17. (a) **Burial** (b) Date thereof **Sept 4 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **W. B. Steller**

(b) Address **Wellsville Mo**

19. (a) **9-6-45** (b) **Thos Meritt**
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 10-3-45

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 Self

Registered Apprentice No.

working under my personal supervision.

Signed A. B. Kellos

Licensed Embalmer No. 1788

P. O. Address Kellogg 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.