

7. S. No. 2  
FORM-8-43  
Rev. 5-17-39  
I X37823

32713

DEPARTMENT OF COMMERCE. THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS. STANDARD. CERTIFICATE OF DEATH.

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1007

Registrar's No. 4415

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson city  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Research Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 16 days  
(Specify whether years, months or days) 16 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray  
(c) City or town Raymo. Grape Mo. Co  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes of No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EVA MAY HALDEY

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex FE 5. Color or race wh 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Albert Halder 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased July 24, 1886  
(Month) (Day) (Year)

8. AGE: Years 59 Months 3 Days 2 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Wm. D. Wheeler  
13. Birthplace Pennesse (City, town, or county) (State or foreign country)

14. Maiden name Arny Smith  
15. Birthplace Raymo Missouri (City, town or county) (State or foreign country)

16. (a) Informant Albert Halder  
(b) Address Raymo, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-45 (Month) (Day) (Year)  
(c) Place: burial or cremation Black Ops Cem.

18. (a) Signature of funeral director Alfred Mead  
(b) Address Raymo, Mo

19. (a) 10-27-45 (Date received local registrar) (b) Eveline Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26 year 1945 hour 9 minute 050 M.

21. I hereby certify that I attended the deceased from Oct 10 - 1945 to Oct 26 - 1945; that I last saw her alive on Oct 26 - 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Generalized peritonitis  
Due to Ruptured gangrenous appendixitis  
Duration 18 days

Other conditions (Include pregnancy within 3 months of death) 12:1

Major findings: Of operations \_\_\_\_\_ Of autopsy As Above

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) (Specify type of injury)  
23. Signature H. B. Altbach (M. D. or \_\_\_\_\_)  
Address 7300 Holmes, K.C. Mo. Date signed 10-26-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

NOV 8 1942

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.....  
*Body will be embalmed*..... Registered Apprentice No.....  
working under my personal supervision.

Signed.....*Donald F. Wood*.....

Licensed Embalmer No. *2801*.....

P. O. Address.....*Braymer*.....

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.