

No. 2
-5-43
5-17-39
D I X36671

FILED OCT 17 1945
Registration District No. 323

Primary Registration District No. 60-9-73000 Registrar's No. 2

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Keokukville mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Erwin Smith
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community 18 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Schuyler
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Hera Maxine Erwin

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Fi / 5. Color or race w
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife C 6. (c) Age of husband or wife if alive 2 years
7. Birth date of deceased Nov 7 1926
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
18 8 24 hr. min.

9. Birthplace Schuyler Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Earl Erwin
13. Birthplace Schuyler Co mo
(City, town, or county) (State or foreign country)
14. Maiden name Maie Wheatley
15. Birthplace Schuyler Co mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Earl Erwin
(b) Address Downing mo

17. (a) Burial (b) Date thereof Sept 10-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Coffey

18. (a) Signature of funeral director Ford Moore
(b) Address 10 owners mo

19. (a) Sept 11-1945 (b) Public H. Drake-Deputy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 1st year 1945 hour 4 minute 00 P. M.
21. I hereby certify that I attended the deceased from Aug 22nd, 1945, to Sept 1st, 1945; that I last saw her alive on Sept 1st, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolus following operation - 11th day
Duration 10 min

Due to —
Due to

Other conditions Subacute appendicitis
(Include pregnancy within 3 months of death) 11th day

Major findings: Of operations subacute appendicitis
Of autopsy 21:2
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?

While at work? (Specify type of place) (c) Means of injury —

23. Signature George E. Brown (M. D. or other) MD
Address Keokukville, Missouri Date signed 9-4-45

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

1617

RECEIVED

District Health Officer No. 10

District File Number 10-45-1533

Date Filed OCT. 16 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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Lloyd Moore

Licensed Embalmer No. 3131

P. O. Address Downing 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 2

Registration District No. 1 Primary Registration District No. 3000

1. PLACE OF DEATH:

- (a) County Madison
- (b) City or town Wassonville
(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 (Specify whether

In this community
years, months or days)

3. (a) PRINT FULL NAME Vera M Erwin

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 7 years

7. Birth date of deceased Nov - 7
(Month) (Day) (Year)

8. AGE: Years 18 Months 0 Days 0 Unless than one day hr. min.

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

10. Usual occupation at home

11. Industry or business None

12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10-19-45 (b) (Kate Lambert)
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
- (c) City or town..... (If outside city or town limits, write "RURAL")
- (d) Street No..... (If rural, give location)
- (e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1945 hour 1 minute 1 M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him/her alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN

Underline the cause of death which 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?.....

While at work? (Specify type of place) (e) Means of injury.....

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

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

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

MOTHER, FATHER

SUPPLEMENTARY

32982