DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33077

FILED NOV 8 1945

Registration District No. 9-2 Primary Registration District No. 4042 Registrar's No. 54

1. PLACE OF DEATH:
(a) County Bollinger,
(b) City or town Lutesville, Lorence.
(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 years, months or days)
In this community All her life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Bollinger 9
(c) City or town Marble Hill 0
(If outside city or town limits, write "RURAL")
(d) Street No. ✓ 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mrs Sophia Cheek.
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 Widowed
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Sept, (Month) 17th (Day) 1861 (Year)

8. AGE: Years 84 Months 1 Days ## 7 If less than one day hr. min.

9. Birthplace Bollinger Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation House Keeper.
11. Industry or business

MOTHER FATHER
12. Name Dont Know.
13. Birthplace (City, town, or county) 4 (State or foreign country)
14. Maiden name ~~Unknown~~
15. Birthplace (City, town, or county) 4 (State or foreign country)

16. (a) Informant Hazel Underwood.
(b) Address Cuba Mo,
17. (a) Berrial (Burial, cremation, or removal) (b) Date thereof Oct 24th 45 (Month) (Day) (Year)
(c) Place: burial or cremation Old Tracey Creek
Baker Funeral Home,
18. (a) Signature of funeral director By A J Baker
(b) Address Lutesville, Mo,
19. (a) Nov 1-1945 (Date received local registrar) (b) Willie VanAmburgh (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct; day 24th year 1945 hour 9 - minute 20 A. M.
21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...;
that I last saw her alive on 10/19/45 - 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic pneumonia ✓	
Due to Fractured femur. ✓	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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: 9 ✓
(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 John J Myers M.D. (M. D. or other)
Address Lutesville Mo Date signed 11-27-45

1438

(Licensed Embalmer's Statement on Reverse Side)

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

2
8-43
5-17-39
X37823

RECEIVED

District Health Officer No. 4

District File Number 114-5-1287

Date Filed 11-2-45

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed T. E. Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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. 11 01

Registration District No. 32 Primary Registration District No. 4042 Registrar's No. 54

1. PLACE OF DEATH:

(a) County Bollinger

(b) City or town Intervale
(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)

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

3. (a) PRINT FULL NAME Sophia Cheek

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 17 (Day) 1861 (Year)

8. AGE: Years 84 Months 1 Days Hours If less than one day min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17

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 Fgel, Fracturing hip	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accident

(b) Date of occurrence Sept 10 1945

(c) Where did injury occur? Marble Hill (City or town) Bollinger (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury Fall

23. Signature John J Myers (M. D. or other)

Address Fredericktown Mo Date signed 11/2/45

33077