

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

State File No. **33447**

Registration District No. **5-8** Primary Registration District No. **4089** Registrar's No. **22**

1. PLACE OF DEATH:  
(a) County **Carter**  
(b) City or town **Grandin Mo.**  
(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 **Life** \_\_\_\_\_ (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Carter**  
(c) City or town **Grandin**  
(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 **MARTHA MAE HIXSON**  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_  
4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept** day **22** year **1945** hour **6** minute **5 A.M.**  
21. I hereby certify that I attended the deceased from **Sept 20** 19**45** to **Sept 22** 19**45**  
that I last saw her alive on **Sept 21** 19**45** and that death occurred on the date and hour stated above.

7. Birth date of deceased **May 8 1945**  
(Month) (Day) (Year)  
8. AGE: Years \_\_\_\_\_ Months **4** Days **14** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death **Labor Pneumonia** Duration **2 days**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace **Grandin Mo. U**  
(City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name **Robert Hixson**  
13. Birthplace **Carter Co. Mo. U**  
(City, town, or county) (State or foreign country)

Other conditions **Colitis**  
(Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy **108**

MOTHER FATHER  
14. Maiden name **Gladys Hix Davis**  
15. Birthplace **Ripley Co. Mo. U**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **Robert Hixson**  
(b) Address **Grandin Mo.**  
17. (a) **Burial** (b) Date thereof **Sept. 23 1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Road Cemetery**  
18. (a) Signature of funeral director **L. W. Edwards**  
(b) Address **Doniphan Mo.**  
19. (a) **Oct. 24-45** (b) **Mrs Octa Hixson**  
(Date received local registrar) (Registrar's signature)

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) (Means of injury)  
23. Signature **Clifford Jofort** (M. D. or other)  
Address \_\_\_\_\_ Date signed **9-22-45**

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

RECEIVED

District Health Officer No: 5,

District File Number 1145-408

Date Filed 11.6.45.

NOV 9 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.....

*Not embalmed*

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

working under my personal supervision.

Signed *L. Eaton Purvitt*

Licensed Embalmer No. 2287

P. O. Address New Bureau

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.