

No. 2
-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33481

State File No. _____

FILED OCT 25 1945

Registration District No. _____

Primary Registration District No. 4107

Registrar's No. 47

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town Eldorado spgs 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 _____ (Specify whether _____)
In this community _____ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Cedar 20
(c) City or town Eldorado spgs 1
(If outside city or town limits, write "RURAL")
(d) Street No. 401 A Grand 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month oct day 7
year 1945 hour 4 minute 30 PM
21. I hereby certify that I attended the deceased from Sept 1 1945 to Oct 7 1945
that I last saw him alive on sep 7 1945
and that death occurred on the date and hour stated above.
Immediate cause of death myocardial Duration _____

3. (a) PRINT FULL NAME Mary Crocker Whittlesey
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race _____ 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 9 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>10</u>	<u>26</u>	hr. _____ min. _____

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

10. Usual occupation Home work

11. Industry or business _____

12. Name Samuel Whittlesey

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

14. Maiden name Ellen E. Marchessault

15. Birthplace Brownhelm Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Grace Baldrige

(b) Address Eldorado spgs mo

17. (a) Burial (b) Date thereof 10-8-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheldon

18. (a) Signature of funeral director Proper Funeral Home

(b) Address Eldorado spgs mo

19. (a) 10/4/45 (b) _____
(Date received local registrar) (Registrar's signature)

Due to stintility
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 9/24
Of autopsy _____

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 L T Dunaway (M. D. or other) _____
Address Eldorado spgs mo Date signed 10/8/45

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

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

RECEIVED

Office No. 7

Date Filled 9-15-1040

10-23-45

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 *George W. Mafus*

Licensed Embalmer No. 27521

P. O. Address *Edonole spgs*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *N 5 n*Registration District No. *61*Primary Registration District No. *4107*Registrar's No. *87*

1. PLACE OF DEATH:

- (a) County *Cedar*
 (b) City or town *El Dorado Springs*
 (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 *Mary C. Whittlesey*3. (b) If veteran,
name war.....3. (c) Social Security
No.....4. Sex *F*5. Color or
race *(white)*6. (a) Single, widowed, married,
divorced *S*

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if
alive..... years7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

*82**10**2*

hr. min.

9. Birthplace.....
(City, town, or county) (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) *J. B. ...*
(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 *10* Day *10*
year *1941* hour..... minute..... M.21. I hereby certify that I attended the deceased from.....
to....., 19.....
that I last saw him..... 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 to
which death
should be
charged sta-
tistically.

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

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

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

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

SUPPLEMENTARY

33481