No. 2
—5-43
-17-39
X36671

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

FILED NOV 8 1945

State File No. 34319

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 273

1. PLACE OF DEATH:

(a) County pettis

(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 216 W. Cooper, st. 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 40 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County pettis 80

(c) City or town Sedalia 6
(If outside city or town limits, write "RURAL")

(d) Street No. 216 W. Cooper, st. 4
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME Mary Ceasar

3. (b) If veteran, name war .....

3. (c) Social Security No. none

4. Sex F 3

5. Color or race Negro

6. (a) Single, widowed, married, divorced ~~Married~~ Widowed

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

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

7. Birth date of deceased Feb. (Month) 2 (Day) 1867 (Year)

8. AGE: Years 78 Months 8 Days 7 If less than one day ..... hr. ..... min.

9. Birthplace Calloway County, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business .....

FATHER
12. Name Joseph Pounds
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elvira Hughes
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Roxella Smith
(b) Address 216 W. Cooper, st. Sedalia, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (Month) (Day) (Year)
(c) Place: burial or cremation Crown Hill Annex Cem.

18. (a) Signature of funeral director J. Pryce Alexander
(b) Address 400 W. Cooper st. Sedalia, Mo.

19. (a) 10-15-45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct day 9
year 1945 hour 2:30 minute ..... M.

21. I hereby certify that I attended the deceased from 10/9, 1945 to 10/9, 1945
that I last saw her alive on 10-9, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma ✓ Duration One year

Due to .....

Due to .....

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

ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

Major findings:
Of operations .....
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:

(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 [signature] (M. D. or other) M. D.
Address Sedalia Date signed 10/12/45

1486

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Local Health Officer No. 8,
District File Number
Date Filed 11-7-45

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 J. J. Alexander

Licensed Embalmer No. 4245

P. O. Address Sedalia 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.

S. No. 2B
M—5-43
Seq 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. 1102

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 273

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(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

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 Mary Clasan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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 Feb. 2 (Month) (Day) (Year)

8. AGE: Years 78 Months 8 Days Unless than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 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)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from 19 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 Cancer of the tongue

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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)

(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

45 H

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