

S. No. 2
FORM-2-43
Rev. 5-17-39
I X35937

37590

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

State File No. _____

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 198

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: Storer Memorial Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 hours
(Specify whether years, months or days)

In this community 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State IOWA (b) County unk. 799

(c) City or town Rockwell 13
(If outside city or town limits, write "RURAL")

(d) Street No. --- 0
(If rural, give location)

(e) Citizen of foreign country? no 2 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Evelyn Pearl Light

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced married

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

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Jan 26 1915
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>30</u>	<u>9</u>	<u>17</u>	hr. _____ min _____

9. Birthplace Calhoun County IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business ---

MOTHER FATHER { 12. Name LORRIE FARBER

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

{ 14. Maiden name ALICE DILBACK

{ 15. Birthplace unknown ILLINOIS
(City, town, or county) (State or foreign country)

16. (a) Informant Edwin Light

(b) Address Rockwell, IOWA

17. (a) Removal (b) Date thereof Nov 13-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rockwell, IOWA

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage, Mo

19. (a) 11-13-45 (b) P.B. Coontz, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 13
year 1945 hour 2:55 minute a. M.

21. I hereby certify that I attended the deceased from Nov 12, 1945, to Nov 13, 1945
that I last saw her alive on Nov 13, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Durjon

Prophylactic Asthma 34yr.

Due to _____

Due to _____

Other conditions Hypostatic Congestion
(Include pregnancy within 9 months of death)

Major findings: 43yr
Of operations _____

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)

(a) Means of injury _____

23. Signature Albert B. Wheeler, M.D. Do.
Address Carthage, Mo Date signed 11/13/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

49
201

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.....

..... *Frank W. Kneel*, Registered Apprentice No. *379*,
working under my personal supervision.

Signed..... *Emma R. Snell*

Licensed Embalmer No. *391*

P. O. Address..... *Carthage*

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.