

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37726**

FILED NOV 30 1945
Registration District No. 10730

Primary Registration District No. 3033

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Laclede
 (b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Wallace Hospital
(If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Trinidad B. W. I.
 (b) City or town Port Of Spain
(If outside city or town limits, write "RURAL")
 (c) Street No. _____
(If rural, give location)
 (d) Citizen of foreign country? Yes (Yes or No)
 If yes, name country British

3. (a) PRINT FULL NAME Molly Massy
 (b) If veteran, name war _____
 (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov. day 15
 year 1945 hour 6 minute _____ A.M.

4. Sex F / 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Chas. Rochester Massy
 (c) Age of husband or wife if alive 48 years
 7. Birth date of deceased Feb 27th 1897
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-12-45 to 11-15-45
 that I last saw him alive on 11-15-45
 and that death occurred on the date and hour stated above.

8. AGE: Years 48 Months 8 Days 18
 If less than one day hr. _____ min. _____

Immediate cause of death Cerebral embolism
 Duration _____

9. Birthplace Trinidad, British West Indies
(City, town, or county) (State or foreign country)
 10. Usual occupation House Wife

Due to auto accident
 Due to _____

11. Industry or business _____
 12. Name Jas, (Tertius) Wilson
 13. Birthplace Scotland
(City, town, or county) (State or foreign country)
 14. Maiden name Louise Goodwille
 15. Birthplace Trinidad
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

16. (a) Informant Port of Spain B. W. I.
 (b) Address Cremation
 (c) Place: burial or cremation Palmer Funeral Home
 17. (a) Cremation (b) Date thereof 11-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 18. (a) Signature of funeral director Lebanon Mo
 (b) Address _____
 19. (a) 11-16-45 (b) Orin H. Frankenberg
(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) auto accident
 (b) Date of occurrence 11-12-45
 (c) Where did injury occur? Camden B. Mo
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway #5.
(Specify type of place) (c) Means of injury
 While at work? _____
 23. Signature J. R. Kerrell (M. D. or other) MD
 Address Lebanon Date signed 11-15-45

1463 (Licensed Embalmer's Statement on Reverse Side)

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

Received.....

Laclede County Health Unit

File No. 11-45-155

Date Filed 11/29/45

DEC 13 1945

NOV 30 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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Allyn Dolhuze, Embler

Licensed Embalmer No. 4333

P. O. Address St. Louis

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8 7726

Registration District No. 170

Primary Registration District No. 3083

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Leake
(b) City or town Lebanon
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Molly Masey
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 M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

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

8. AGE: Years 48 Months 8 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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 _____ Day _____ Year 1945 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ and that death occurred on the date and hour stated above.

Immediate cause of death while riding in auto on Highway #5 near Camden Mo. the auto left the road and crashed into ditch. Cop driver by husband. No other vehicle was involved. Duration _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 11-12-45

(c) Where did injury occur? Camden Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway #5

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature B. E. Danell (M. D. or other) MD

Address Lebanon Mo Date signed 2-12-46

SUPPLEMENTARY

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

MOTHER, FATHER

