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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

40890

FILED DEC 29 1945

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 20

Primary Registration District No. 4106

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Pedlar

(b) City or town Juno Springs 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 life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cedar 20

(c) City or town Juno Springs Mo
(If outside city or town limits, write "RURAL")

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

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

If yes, name country

3. (a) PRINT FULL NAME JENNIE S WILLHOITE

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female 5. Color or race W

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

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

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased 12 (Month) 1865 (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>4</u>	<u>21</u>	hr. min.

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

10. Usual occupation House wife

11. Industry or business

12. Name William Humphrey

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

14. Maiden name unknown

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

16. (a) Informant Mrs. Wm G. Albrecht

(b) Address Juno Springs Mo

17. (a) Burial (b) Date thereof Nov 12 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beashee Cemetery

18. (a) Signature of funeral director es B Beashee

(b) Address Sheldon Mo

19. (a) 11-12-45 (b) Marion May Callis
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11
year 1945 hour 1 minute 45 AM

21. I hereby certify that I attended the deceased from 9-20-45
1945 to 11-11 1945

that I last saw h. alive on 11-11
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis
nephritis

Due to Hypertension and
Heart plegia

Due to

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

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?

While at work? (Specify type of place)

(e) Means of injury

23. Signature J P Barman (M. D. or other)

Address Juno Springs Mo Date signed 11-12-45

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

MOTHER FATHER

1434

(Licensed Embalmer's Statement on Reverse Side)

RENEWED

Division Health Officer No. 7,

License No. 11-43-1236

Expiry Date 12-22-45

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.....

Carroll T. Berry

Licensed Embalmer No.....

2385

P. O. Address.....

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. Jan
Registrar's No. 5

Registration District No. 60 Primary Registration District No. 4/06

1. PLACE OF DEATH:
(a) County Cedar
(b) City or town Jerico Spring
(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

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 Jennie S. Willhoite
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 w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 20 (Month) (Day) (Year)

8. AGE: Years 20 Months _____ Days _____ If less than one day 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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 _____ to _____, 19____, and that death occurred on the date and hour stated above.
Duration _____
Immediate cause of death Chronic Nephritis

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy 10/18

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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? _____

While at work _____ (Specify type of place) (c) Means of injury _____
23. Signature Jennie S. Willhoite (M. D. or other) _____
Address Jerico Spring Date signed _____

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

SUPPLEMENTARY

40890