

...s. No. 2
OM-8-43
v. 5-17-39
-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 14 1946
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42561

State File No. _____

Registration District No. 2

Primary Registration District No. 6084

Registrar's No. 24

1. PLACE OF DEATH:

(a) County SALINE

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

(c) Name of hospital or institution: Rural 1
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 5 1/2 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County SALINE 94

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

(d) Street No. 1/2 mi West of Blaskwater, Mo.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME CORA SLOAN CUNDIFF

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 14
year 1945 hour 4 AM minute 5 min.

21. I hereby certify that I attended the deceased from Dec 1 4:30 to Dec 14 8:30
that I last saw her alive on Nov 21 1945
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race white 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 JUNE 20 1865
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis 19 yrs

Due to arterial sclerosis 2-

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

8. AGE: Years 80 Months 5 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name CHRISTER E. CUNDIFF

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

14. Maiden name MARIAL CRAIN

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations 1 30

Of autopsy _____

16. (a) Informant Blay Cundiff

(b) Address Blaskwater, Mo

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 _____

17. (a) BURIAL (b) Date thereof 12-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HAZEL G. ROUE CEMETERY

18. (a) Signature of funeral director R. G. Carter

(b) Address Blaskwater, Mo

19. (a) Dec. 15, 1945 (b) Mrs. W. E. Shackelford
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) _____

Address _____ Date signed 12/15/45

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

17
00

1253

RECEIVED

District Health Officer No. 8

District File Number

Date Filed 1-11-46

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 P. C. Carter

Licensed Embalmer No. 3513

P. O. Address Summit Springs, N.C.

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.