No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 28 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4465

Registration District No. 1 Primary Registration District No. 5009 Registrar's No.

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

3495

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Rural Wilson Township
(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 79 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County ADAIR

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Katherine Cain

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 widow

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 16 (Day) 1860 (Year)

8. AGE:

Years	Months	Days	If less than one day
85	4	1	hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

FATHER
12. Name James L Wheeler
13. Birthplace Ky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Bains
15. Birthplace Ky (City, town, or county) (State or foreign country)

16. (a) Informant J Laton Wheeler

(b) Address Kirksville Route No 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (Month) 20 (Day) 1946 (Year)

(c) Place: burial or cremation LaClota

18. (a) Signature of funeral director D S Christie

(b) Address LaClota Mo

19. (a) 3-4-46 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 17" day FEB. year 1946 hour 3 minute 30 A.M.

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

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to Myocardial Degeneration	
Due to Infirmities of age	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 107	

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 F. R. Easley Coroner (M. D. or other)

Address Brashear Mo. Date signed 2/18-46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-46-290
Date Filed FEB 25 1946

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 D. S. Christie

Licensed Embalmer No. 1109

P. O. Address La Plata 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—3-45
1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mar

Registration District No. 1 Primary Registration District No. 5009 Registrar's No.

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Rural Wilson Twp

(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 Katherine Cain

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 16 1860 (Month) (Day) (Year)

8. AGE: Years 85 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) Ky (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) 3-4-46 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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:

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(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

3495 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

4465