

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

Registration District No. **141**

Primary Registration District No. **2025**

Registrar's No. **29**

1. PLACE OF DEATH:

(a) County **Howell**  
 (b) City or town **West Plains**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **1**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Howell**  
 (c) City or town **West Plains**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Sella Washington**

3. (b) If veteran, name war  3. (c) Social Security No.

4. Sex **71** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **SO**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: **Exact date unknown**  
 (Month) (Day) (Year)

8. AGE: Years **84** Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **none**

11. Industry or business \_\_\_\_\_

12. Name **Jesse D Washington**

13. Birthplace **W Va** (City, town, or county) (State or foreign country)

14. Maiden name **Sarah M. Dabman**

15. Birthplace **W Va** (City, town, or county) (State or foreign country)

16. (a) Informant **Sella Washington**

(b) Address **West Plains, Mo**

17. (a) **B** (b) Date thereof **2-9-1946**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Howell Valley**

18. (a) Signature of funeral director **Bertsons**

(b) Address **West Plains, Mo**

19. (a) **March 6, 1946** (b) **Blades Harrison**  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **7**  
 year **1946** hour **6** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **2-3-** 19**46**, to **2-7-** 19**46**,  
 that I last saw her alive on **2-5-** 19**46**,  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral arteriosclerosis**  
**Cerebral thrombosis** Duration **2-5-46**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **Senility**  
 (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy **97**

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 **E. C. Bohrer** (M. D. or other) **MO**

Address **West Plains, Mo** Date signed **2-21-46**

RECEIVED

District Health Officer No. 5,  
District File Number 346219  
Date Filed 2-17-46

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.....

Licensed Embalmer No. 3432

P. O. Address West Hampton

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. Ma  
Registrar's No. \_\_\_\_\_

Registration District No. 141 Primary Registration District No. 2025-

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town West Plains  
(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 70 years years, months or days)

3. (a) PRINT FULL NAME Della Washington

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 8

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation NONE

11. Industry or business NONE - LIVED IN HOME FOR AGED OR NURSING HOME

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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell  
(c) City or town West Plains (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 7 Day \_\_\_\_\_ Year 1946 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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) \_\_\_\_\_

(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

5439