

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

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BUREAU OF COMMERCE
THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8257

State File No.

FILED 3 MAY 8 1946
Registration District No.

Primary Registration District No. 61880

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Louis Co

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

(c) Name of hospital or institution:
near Tompville mo
(If not in hospital or institution, write street number or location)

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

In this community Swedish _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Beaver

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

(d) Street No. near Tompville mo
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country none

3. (a) PRINT FULL NAME ROSA V. MITCHELL

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married widowed

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

7. Birth date of deceased: Sept 23 1861
(Month) (Day) (Year)

8. AGE: 84 Years 3 Months 12 Days If less than one day _____ hr. _____ min.

9. Birthplace Waymouth Co Kans
(City, town, or county) (State or foreign country)

10. Usual occupation Nursekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name A J Parby

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

14. Maiden name Sarah Lipton

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

16. (a) Informant Willee Mitchell

(b) Address Tompville mo

17. (a) Burial (b) Date thereof Jan 8 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hephreth Cemetery

18. (a) Signature of funeral director Ralph James

(b) Address Wagoner mo

19. (a) 1-10-46 (b) C. R. Allaman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5 year 1946 hour 6 minute A M.

21. I hereby certify that I attended the deceased from at Deathe Jan 5 1946
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to High Blood pressure

Infarction

Duration 10 Years
1 week

Other conditions old age
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 940

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) _____

(e) Means of injury _____

23. Signature Barry Farryth (M.D. or other) _____

Address Farryth mo Date signed Jan 5 1946

222

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 246-193

Date Filed 2-28-46

REC'D
MAY 11 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

Lawrence L Hall

Licensed Embalmer No.

2784

P. O. Address

Gainesville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Mar
Registrar's No. 63

Registration District No. 351

Primary Registration District No. 6186

1. PLACE OF DEATH:

(a) County Janey Rural
(b) City or town Rural
(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 _____
years, months or days

3. (a) PRINT FULL NAME Rosa U. Mitchell

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 _____

7. Birth date of deceased Send 20
(Month) (Day) (Year)

8. AGE: Years 84 Months 3 Days _____ If less than one day _____ hr. _____ min.

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

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) _____ (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) 11-10-46 (b) C. R. Allaman
(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 _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ 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:

(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 _____

SUPPLEMENTARY

8257