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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED MAR 18 1946 STANDARD CERTIFICATE OF DEATH

State File No. 8401

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Audrain

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

(c) Name of hospital or institution:
Audrain Co. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether)

In this community life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Centrabia Rt # 4
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIE FRANCES DOUGLASS

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19
year 1946 hour 4 minute 45 A.M.

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

6. (b) Name of husband John Thomas Douglas 6. (c) Age of husband or wife if alive ✓ years 22

7. Birth date of deceased: Sept (Month) 5 (Day) 1862 (Year)

21. I hereby certify that I attended the deceased from June 9, 1946, to February 18, 1946, that I last saw her alive on Feb - 18, 1946 and that death occurred on the date and hour stated above.

8. AGE: Years 83 Months 3 Days 14
If less than one day hr. min.

Immediate cause of death: Intestinal obstruction Duration 1 mo.

Due to suspected carcinoma 1 yr.

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

Due to _____

Other conditions: Arteriosclerosis 10 yrs.
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business ✓

12. Name William Thomas Herzig

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

14. Maiden name Unknown Hasmon

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

16. (a) Informant Arthur Douglas

(b) Address Centrabia Rt # 4

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-21-1946
(Month) (Day) (Year)

(c) Place: burial or cremation Centrabia

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? _____

18. (a) Signature of funeral director John Herzig

(b) Address Centrabia Mo

19. (a) 2/21/46 (Date received local registrar) (b) Blanche Deely (Registrar's signature)

(Specify type of place) _____

(e) Means of injury 17

23. Signature Lepold Lachance, M.D. (M. D. or other) M.P.
Address Centrabia Mo Date signed 2/24/46

FEB 28 1950

RECEIVED
District Health Officer No. 10
District File Number 3-46-477
Date Filed MAR 15 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: Grant Garrison
Licensed Embalmer No. 4370
P. O. Address Centralia, 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. April
Registrar's No. 39

Registration District No. 10

Primary Registration District No. 8002

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Merioux
(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) (Specify whether

3. (a) PRINT FULL NAME Willie F. Douglas

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 & D

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

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

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) _____ (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 April Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____ Duration _____

Due to Suspected carcinoma of colon

Due to _____

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

Major findings: Of operations _____ Of autopsy _____ ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 462 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 Rephold Lachner (M. D. or other) _____

Address Centralia, Mo. Date signed 3/23/46

78865 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

8401