

Registration District No. **296** Primary Registration District No. **6019**

**1. PLACE OF DEATH:**  
(a) County **Ray**  
(b) City or town **Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**2 1/2 miles south east of rural**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **60 years** (Specify whether)  
years, months or days

**3. (a) PRENT FULL NAME** **HETTIE G. DORTON**  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

**4. Sex** **Female** **5. Color of race** **White**  
**6. (a) Single, widowed, married** **divorced married**  
**6. (b) Name of husband or wife** **William B. Dorton**  
**6. (c) Age of husband or wife if** **75** years  
**7. Birth date of deceased** **March 7 1874**  
(Month) (Day) (Year)

**8. AGE:** Years **71** Months **11** Days **27** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

**10. Usual occupation** **Housekeeper** **9**

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

**12. Name** **William Wilson**

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

**14. Maiden name** **Joan Oglin**

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

**16. (a) Informant** **W. B. Dorton**

**(b) Address** **Route 2 - Erick, Mo.**

**17. (a) Burial** (Burial, cremation, or removal) **(b) Date thereof** **3 46**  
(Month) (Day) (Year)

**(c) Place: burial or cremation** **South Point**

**18. (a) Signature of funeral director** **B. W. Wood**

**(b) Address** **Erick, Mo.**

**19. (a) 3-2-46** (Date received local registrar) **(b) Helen J. Parkin** (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Mo** (b) County **Ray**  
(c) City or town **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 \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **March** day **1st**  
year **1946** hour **12** minute **50 P.M.**

**21. I hereby certify that I attended the deceased from** **Jan. 1** 19**45** to **Dec. 11** 19**45**  
that I last saw him alive on **Dec. 11** 19**45**  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
**Coronary Dissection** **1 year**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations **930**  
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)  
(c) Means of injury \_\_\_\_\_  
**23. Signature** **Virgil E. Shade** (M. D. or other)  
Address **Erick, Mo.** Date signed **2-3-46**

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number .....

Date Filed 4-9-46 .....

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. Self  
working under my personal supervision.

Signed Victor E. Leminger

Licensed Embalmer No. 2898

P. O. Address Liberty, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 11

Registration District No. 296

Primary Registration District No. 6019

1. PLACE OF DEATH:

(a) County Ray Rural  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2 1/2 mi. S.E. ORRICK.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 60 yrs. years, months or days)

3. (a) PRINT FULL NAME

Hettie H. Boston

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

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

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

7. Birth date of deceased Mar 4  
(Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 15 (If less than one day, hr. min.)

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (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 \_\_\_\_\_ Year \_\_\_\_\_ 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

MOTHER FATHER

10482