

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED MAY 25 1946 STANDARD CERTIFICATE OF DEATH

State File No. **14002**

Registration District No. _____

Primary Registration District No. **5880**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Osage**
(b) City or town **Rural Linn Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None** (Specify whether
In this community **50 yrs.** years, months or days)

3. (a) PRINT FULL NAME **Douglas C. Deming**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **Sept. 10, 1858** (Month) (Day) (Year)

8. AGE: Years **87** Months **6** Days **9** If less than one day hr. _____ min. _____

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Henry Heibrink**

(b) Address **Mint Hill, Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Mar 21, 46** (Month) (Day) (Year)

(c) Place: burial or cremation **Useful, Mo.**

18. (a) Signature of funeral director _____

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

19. (a) **Mar 20-1946** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Osage** **76**
(c) City or town **Rural** (If outside city or town limits, write "RURAL")
(d) Street No. **Mint Hill, Mo., RFD** (If rural, give location)
(e) Citizen of foreign country? **NO.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **29** year **1946** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Feb 21** 19**46** to **March 4, 1946** that I last saw him alive on **March 4, 1946** and that death occurred on the date and hour stated above.

Immediate cause of death: **Hypostatic Pneumonia**
Chronic Bronchitis
Paroxysmal Tachycardia
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: Of operations _____
Of autopsy **NO**

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 **[Signature]** (M.D. or other) **DO**
Address **Linn** Date signed **3-19-46**

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 5-7-46

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... Vernon M. Morton

Licensed Embalmer No. 4125

P. O. Address Leser

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.