

S. No. 2
M-5-43
5-17-39
P I X3667

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED JUN 13 1948
STANDARD CERTIFICATE OF DEATH

State File No. **16162**
Registrar's No. **47**

Registration District No. **98** Primary Registration District No. **5365**

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

1. PLACE OF DEATH:
(a) County **Saline**
(b) City or town **Hilman City, Mo Rural**
(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 **1 year 7 months 1 day** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **Linn**
(c) City or town **Hilman City, Mo Rural**
(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 _____

3. (a) PRINT FULL NAME **CHERYL FRANKIE ARCHER**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 13 1944**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **4** day **14**
year **46** hour **3** minute **15 P.M.**
21. I hereby certify that I attended the deceased from **April 14 1946** to **April 14 1946**
that I last saw her alive on **April 14 1946**
and that death occurred on the date and hour stated above.

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

Immediate cause of death **Dr. Jabar Pneumonia** Duration **2 hrs.**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **108**
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

9. Birthplace **Wright Hospital Trenton MO** (City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
12. Name **Benzon Franklin Archer**
13. Birthplace **Hilman City, Mo Rural** (City, town, or county) (State or foreign country)
14. Maiden name **Erna L. Dale**
15. Birthplace **Hilman City, Mo Rural** (City, town, or county) (State or foreign country)
16. (a) Informant **Mabel Dale**
(b) Address **Hilman City, Mo**
17. (a) **Burial** (b) Date thereof **April 15 1946** (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Piloths cemetery**
18. (a) Signature of funeral director **W. J. Haines**
(b) Address **Hilman City, Mo**
19. (a) **May 23 1946** (b) **Regina M. English** (Date received local registrar) (Registrar's signature)

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 **2**
23. Signature **J. C. Walker** (M. D. or other) **DO**
Address **Hilman City, Mo** Date signed **4-15-46**

AUG 5 1948

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

W. D. Haines....., Registered Apprentice No.....
working under my personal supervision.

Signed *W. D. Haines*.....

Licensed Embalmer No. *942*.....

P. O. Address *Liberty City 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.