. No. 2
1—2-43
5-17-39
I X35697

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

15390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16514

FILED JUN 10 1946

Registration District No. 1940

Primary Registration District No. 4233

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Iron

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

(c) Name of hospital or institution: Ursuline Academy 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 14 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron 47

(c) City or town Arcadia 0
(If outside city or town limits, write "RURAL")

(d) ~~Street No.~~ Ursuline Academy 0
(If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Mother Clotilde Fox

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife .....

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

7. Birth date of deceased May (Month) 15 (Day) 1863 (Year)

8. AGE:

Years	Months	Days	If less than one day
83	11	20	..... hr. ..... min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Teacher

11. Industry or business .....

FATHER
12. Name Michael Fox 4
13. Birthplace ..... (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Hannah Mamon 11
15. Birthplace ..... (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Mother Carmelita

(b) Address Arcadia, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-46 (Month) (Day) (Year)

(c) Place: burial or cremation Arcadia Mo

18. (a) Signature of funeral director Norman White & Sons

(b) Address Ironton Mo

19. (a) May 20-46 (Date received local registrar) (b) Mrs Avis Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5
year 1946 hour 5 minute 10 A.M.

21. I hereby certify that I attended the deceased from May 4th, 1946, to May 5th, 1946, that I last saw her alive on May 4th, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: acute Bi-lateral Bronchial Pneumonia — Duration 5/5/46.

Due to acute naso-pharyngitis — 5/1/46.

Due to (1) Senility (2) chronic arthritis ?

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

10

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)

While at work? ..... (e) Means of injury 0

23. Signature J. E. Harland (M. D. or other) M.D.

Address Ironton, Mo. Date signed 5-7-46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 646-2217

Date Filed 6-8-46

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 Ancel J. White

Licensed Embalmer No. 3412

P. O. Address Trenton 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.