

No. 3
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17169**

FILED JUN 7 1946

Registration District No. 171

Primary Registration District No. 5639

Registrar's No. \$

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Rural, Washington Twp.
(If outside city or town limits, write "RURAL" and name of township)
(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 All her life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 54
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 8 Mi. SE of Odessa
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10
year 1946 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from on
May 10, 1946 to _____, 19_____;
that I last saw her alive but was dying _____, 19_____;
and that death occurred on the date and hour stated above.
Underline the cause of death. _____ Duration _____

Cardinal Hemorrhage
Hypertension
Arteriosclerosis

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

Major findings: Of operations _____
Of autopsy 30

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

3. (a) PRINT FULL NAME Francis Ella White

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 Wid

6. (b) Name of husband or wife George 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased April 1st 1881
(Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 10 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Frederick Hader

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Hurr

15. Birthplace Penn 1
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth White

(b) Address Mayview, Mo.

17. (a) Burial (b) Date thereof 5/12/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Taber

18. (a) Signature of funeral director [Signature]

(b) Address Higginsville, Missouri.

19. (a) James [Signature] 1946 (b) Letta [Signature]
(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 _____

23. Signature [Signature] (M. D. or other) _____
Address [Signature] Date signed 5/2/46

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6-6-76

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 *Gust W. Reikof*

Licensed Embalmer No. *3637*

P. O. Address *Hopkinton*

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. June

Registration District No. 171

Primary Registration District No. 5629

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Osceola Rural
(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

3. (a) PRINT FULL NAME Francis E. White

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 widow

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

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

8. AGE: Years 65 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 _____

MOTHER FATHER

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) June 11 1946 (b) Father Drummond
(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 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration

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) (c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

