

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 220

Registration District No. 47 Primary Registration District No. 3008

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(c) Name of hospital or institution State Hosp # 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 yrs 28 days
In this community 5 yrs 28 days
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Dunklin
(c) City or town Keokuk
(If outside city or town limits, write "RURAL")
(d) Street No. 206 S Vandewater
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John C Bird
(b) If veteran name war No
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 17
year 1946 hour 6 minute 45 A.M.
21. I hereby certify that I attended the deceased from March
1, 1946, to June 17, 1946
that I last saw him alive on June 16, 1946
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
(b) Name of husband or wife _____
(c) Age of husband or wife if alive _____ years

Immediate cause of death Pulmonary tuberculosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 131
Of autopsy _____

7. Birth date of deceased: April 13 1921
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
25 2 4 hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER
12. Name John Bird
13. Birthplace Genessee
(City, town, or county) (State or foreign country)
14. Maiden name May Nations
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Wing Reed
(b) Address _____

17. (a) Removal (b) Date thereof 6-17-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Keokuk - Mo

18. (a) Signature of funeral director Blum
(b) Address Fulton Mo

19. (a) 6-17-1946 (b) Joac Mosierhoff
(Date received local registrar) (Registrar's signature)

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 _____
23. Signature Wm J. Gremer (M. D. or other) _____
Address Fulton Date signed 6/17/46

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

10015

14
12

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 1-8-46

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 J. J. Patton
Licensed Embalmer No. 2558
P. O. Address Fuller Md

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.