

V. S. No. 2
00M-8-13
Rev. 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

1965

State File No. _____

FILED JUN 9 1946

Primary Registration District No. 3008

Registrar's No. 214

1. PLACE OF DEATH:

(a) County Calloway

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

(c) Name of hospital or institution:
State Hospital no. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 1/2 days
(Specify whether years, months or days)

In this community same
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Co.

(c) City or town Manchester Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHRISTINE NAIDEN

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 widow

6. (b) Name of husband or wife deceased

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

7. Birth date of deceased no (Month) 2 (Day) 1864 (Year)

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

81 7 9 hr. _____ min.

9. Birthplace New York
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name DK _____

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

{ 14. Maiden name DK _____

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

16. (a) Informant Recd. State Hospital no. 1

(b) Address Fulton Mo.

17. (a) Removal (b) Date thereof 6-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Missouri

18. (a) Signature of funeral director Wallace Funeral Home

(b) Address Fulton Mo.

19. (a) 6-11-1946 (b) Josie Mousatloff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jun day 11
year 1946 hour 12 minute 11 a M.

21. I hereby certify that I attended the deceased from Jun 1
9 1946, to Jun 11 1946
that I last saw her alive on Jun 10 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to _____

Due to _____

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

Major findings: 930

Of operations _____

Of autopsy _____

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 _____

Signature W. E. Shull (M. E. of Board)
Address Fulton Mo. (City or town) (County) (State)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

(Licensed Embalmer's Statement on Reverse Side)

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

14
1
2

18720

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 7-8-46

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 Denzil E. Browning
Licensed Embalmer No. 2724
P. O. Address Fulton 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.