M—8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 8 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22899

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 249

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

1. PLACE OF DEATH:

(a) County Callaway

(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 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6M-19d (Specify whether

In this community years, months or days) years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Callaway 14

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

(d) Street No. 2 (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Charles Killes Sexton

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MO

5. Color or race W

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 June (Month) 10 (Day) 1877 (Year)

8. AGE: Years 69 Months 1 Days 5 If less than one day hr. min.

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

10. Usual occupation Railroad Maintenance

11. Industry or business

FATHER
12. Name Turner Sexton
13. Birthplace Boone County, Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Little
15. Birthplace Boone County, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-18 46 (Month) (Day) (Year)

(c) Place: burial or cremation St Louis Mo

18. (a) Signature of funeral director Glen Y Mauk

(b) Address Fulton Mo

19. (a) 7-22 1946 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15th year 1946 hour 2 40 minute a. M.

21. I hereby certify that I attended the deceased from 6-18- 1946 to 7-15 1946 that I last saw him alive on 7-14- 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Generalized Arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 93d

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? (Specify type of place)

While at work? (e) Means of injury

Signature J. B. Stokes, M.D. (M. D. or other)

Address Fulton, Mo. Date signed 7/18/46

38

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number 8-46-71
Date Filed 8-7-46

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. I. Russon

Licensed Embalmer No. 25.55

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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 249

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(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)

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

3. (a) PRINT FULL NAME Charles K. Sexton

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased June 10 (Month) 1 (Day) 1 (Year)

8. AGE: Years 69 Months 1 Days 5 If less than one day hr. min.

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

10. Usual occupation Road Maintenance

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) July 22 1946 (Date received local registrar) (b) Josie Marsick Hoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 15 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

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

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 (M. D. or other)

Address Date signed

22899