DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 29 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26111

Registration District No. 374 Primary Registration District No. 4530 Registrar's No. 29

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

1. **PLACE OF DEATH:**
(a) County Worth
(b) City or town Sheridan
(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 20 years
years, months or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Worth
(c) City or town Sheridan
(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 Elizabeth Black
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, 2 divorced widowed
6. (b) Name of husband or wife William Black
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 3 (Day) 1873 (Year)

8. AGE: Years 72 Months 7 Days 28 If less than one day hr. min.

9. Birthplace Athelston (City, town, or county) Iowa (State or foreign country) 1
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Thomas Williams
13. Birthplace Hamilton, Co (City, town, or county) Ohio (State or foreign country) 1
14. Maiden name Julia Housel
15. Birthplace Unknown (City, town, or county) Ohio (State or foreign country) 1
16. (a) Informant Emil Black
(b) Address Sheridan, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-46 (Month) (Day) (Year)
(c) Place: burial or cremation Sheridan, Mo
18. (a) Signature of funeral director Jack C. Dunkle
(b) Address Grant City, Mo.
19. (a) June 9-1946 (Date received local registrar) (b) Lita E. Dawson (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 1
year 1946 hour 9 minute P.M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw her alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to	
Due to	
Other conditions. (Include pregnancy within 3 months of death) 1	
Major findings: Of operations N M	
Of autopsy O	

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) (e) Means of injury

23. Signature Bentley Neal (M. D. or other) DO
Address Grant City Mo Date signed 6-4-1946

(Licensed Embalmer's Statement on Reverse Side)

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 Jack O. Dunlee

Licensed Embalmer No. 3252

P. O. Address Grant City 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.

No. 2B
M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Ana

Registration District No. 274 Primary Registration District No. 4550 Registrar's No. 296

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Sheridan
(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 Elizabeth Black

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 Wid

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

7. Birth date of deceased Oct 3 (Month) (Day) (Year)

8. AGE: Years 72 Months Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER 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) June 9-1946 (Date received local registrar) (b) Leta E. Dawick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 1 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

SUPPLEMENTARY

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

26111