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26965

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 57

FILED SEP 3 1946  
Registration District No. 140

Primary Registration District No. 5549

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

25807

1. PLACE OF DEATH:

(a) County Howard

(b) City or town Fayette *Rural*

(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)

3. (a) PRINT FULL NAME Gabraella Darby

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 Single

6. (b) Name of husband or wife: \_\_\_\_\_

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

7. Birth date of deceased: February 14, 1857

(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>5</u>	<u>17</u>	hr. -- min.

9. Birthplace Howard Co. Missouri

(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name A. C. Darby

13. Birthplace Maryland

(City, town, or county) (State or foreign country)

14. Maiden name Catherine Long

15. Birthplace Howard Co.

(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jeanelle Searcy

(b) Address Fayette, Missouri

17. (a) Burial (b) Date thereof: 8/2/46

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fayette City Cemetery

18. (a) Signature of funeral director Ralph A. Carr

(b) Address Fayette, Missouri

19. (a) 8-5-1946 (b) Dorothy Jean Carr

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard #5

(c) City or town Fayette, Rural 0

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

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31st

year 1946 hour 10:15 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from July 5

1946 to July 31 1946

that I last saw her alive on July 31 1946

and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion 1 day

Due to Ch. In year 1946

Other conditions: \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: Q3D

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 W. B. Searcy (M. D. or other) W.D.

Address Fayette, Mo. Date signed 8-2-46

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 8-31-44

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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, ~~.....~~

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Jayette 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. SeptRegistrar's No. 57Registration District No. 140Primary Registration District No. 5549

## 1. PLACE OF DEATH:

- (a) County Howard  
 (b) City or town Richmond "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 Cabraella Darby

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 S

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

7. Birth date of deceased Feb 14  
 (Month) (Day) (Year)

8. AGE: Years 8-9 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace Rural  
 (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) 8-8-46 (b) Wendy Lee Sabier  
 (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 \_\_\_\_\_ Day \_\_\_\_\_  
 year 1946 (hour) \_\_\_\_\_ (minute) \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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 \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

- Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

26965