

No. 2
M-2-43
5-17-39
1 X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31085

State File No. _____

FILED **OCT 17 1946**

Registration District No. 267

Primary Registration District No. 0896

Registrar's No. 9

1. PLACE OF DEATH:
 (a) County Ozark
 (b) City or town Foil, Rural Noble
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Ozark **77**
 (c) City or town Foil Rural **0**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location) **0**
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Pone Boyd Degase
3. (b) If veteran, name war No
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 23
 year 1946 hour 1 minute 10 A. M.

4. Sex Male **5. Color or race** White
6. (a) Single, widowed, married, divorced, Married/
6. (b) Name of husband or wife Elsie Degase
6. (c) Age of husband or wife if _____ years
7. Birth date of deceased May 16, 1881
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____
 _____, 1946 to Sept 23, 1946
 that I last saw him alive on Sept 22, 1946
 and that death occurred on the date and hour stated above.

8. AGE: Years 65 Months 4 Days 7
 If less than one day _____ hr. _____ min.

Immediate cause of death Coronary De Compensation
 Duration 1 yr

9. Birthplace Foil, Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

Due to Hypertension 10 yr or more
 Due to _____

11. Industry or business _____
12. Name John Degase
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Jane Ford
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Other conditions Fractured Ribs 40 yr
(Include pregnancy within 3 months of death)

16. (a) Informant Mrs Jimmie Degase
(b) Address Fall Mo
17. (a) Burial **(b) Date thereof** 9-24-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Clarke

Major findings:
 Of operations _____
 Of autopsy _____

18. (a) Signature of funeral director Clinkingbeard Funeral H
(b) Address ave Missouri
19. (a) Oct 8, 1946 **(b)** W. J. Harrison
(Date received local registrar) (Registrar's signature)

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? _____

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

299716

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.....

H.B. Nutbrown

Licensed Embalmer No.....

3481

P. O. Address.....

Quia 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.