

No. 2  
-12-45  
5-17-39  
K47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

State File No. 34039  
Registrar's No. 1219

Registration District No. 383 Primary Registration District No. 5655

1. PLACE OF DEATH:  
(a) County Lawrence  
(b) City or town Mt. Vernon  
(c) Name of hospital or institution: State Sanatorium  
(d) Length of stay: In hospital or institution 646 days  
In this community 646 days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Lawrence  
(c) City or town Aurora  
(d) Street No. R 2  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Gertrude Drisel  
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 2 1884

8. AGE: Years Months Days If less than one day  
62 5 23 hr. min.

9. Birthplace Harold County Arkansas  
10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Jim McDonald  
13. Birthplace St. Louis Missouri  
14. Maiden name Elizabeth Woolley  
15. Birthplace Lawrence County Missouri

16. (a) Informant E. McMichael, Record Clerk  
(b) Address Mo. State San. Mt. Vernon, Mo.  
17. (a) Removal (b) Date thereof 9-25-46  
(c) Place: burial or cremation Aurora, Mo.  
18. (a) Signature of funeral director Aurora J. Home  
(b) Address Aurora, Mo.  
19. (a) 10-1-46 (b) R. Philbrick

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 25th  
year 1946 hour 2:50 minute P M.  
21. I hereby certify that I attended the deceased from Dec. 19 1946, to Sept. 25th 1946  
that I last saw her alive on Sept. 25th 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Abt. 3 yrs  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 10/30  
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? \_\_\_\_\_  
(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 R. Helleweg, M.D. (M. D. or other) \_\_\_\_\_  
Address Mt. Vernon, Mo. Date signed 9-25-46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6, /

District File Number 1046-1057

Date Filed OCT 15 1946

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.....

*Myself*....., Registered Apprentice No. 4  
working under my personal supervision.

Signed..... *Osca L. Marsh*  
Licensed Embalmer No. 3812  
P. O. Address..... *Quora 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.

Registration District No. 383 Primary Registration District No. 565d

1. PLACE OF DEATH:  
(a) County Lawrence  
(b) City or town Rural Mt Vernon  
(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 Gertrude Orvil  
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 April 2 (Month) (Day) (Year)  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (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) Removal (b) Date thereof 9-25-46 (Month) (Day) (Year)  
(c) Place: burial or cremation AURORA MO

18. (a) Signature of funeral director AURORA F. HOME  
(b) Address AURORA MO

19. (a) 10/7/46 (b) D. Philbrick  
(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 \_\_\_\_\_ 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)  
(c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY 25-**

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

34039