

No. 2
-12-45
-17-39
X47020

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. 38029
Registrar's No. 239

FILED NOV 27 1946
Registration District No. 294

Primary Registration District No. 6010

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Sugar Creek Township
(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 Missouri (b) County Randolph

(c) City or town R.F.D. 2 Moberly, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. Sugar Creek Township
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Phillip J. Mast

3. (b) If veteran, name war. ✓

3. (c) Social Security No. ✓

4. Sex Male (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: Jan 20th 1856
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9th
year 1946 hour _____ 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 1 1946 to Nov 7 1946
that I last saw him alive on Nov 7 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 10 mo.

8. AGE:

Years	Months	Days	If less than one day
<u>90</u>	<u>9</u>	<u>19</u>	hr. _____ min. _____

Due to arterio sclerosis

Due to _____

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

10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death)

Major findings: none of 3D

Of operations _____

Of autopsy none

11. Industry or business _____

12. Name August Mast

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Schreck

15. Birthplace Germany
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant George Mast

(b) Address RFD #2 Moberly, Mo

17. (a) Burial (b) Date thereof 11-14 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo

18. (a) Signature of funeral director Mahawand Saw

(b) Address Moberly, Mo

19. (a) 11-14-46 (b) Leah Williams Lowe
(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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. Dreyer (M. D. or other) MD

Address Huntsville Mo Date signed 11/12/46

269 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 46-262-2
NOV 26 1946
Date Filed

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 Frank S. Smith
Licensed Embalmer No. 3021
P. O. Address Moherly, 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.