

FILED JAN 29 1947

Registration District No. 06

Primary Registration District No. 5322

Registrar's No. 4-1947

1. PLACE OF DEATH:
 (a) County Crawford
 (b) City or town Cuba, R. III
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution none
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Crawford
 (c) City or town Cuba
(If outside city or town limits, write "RURAL")
 (d) Street No. W. W. #3
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Emma Muller
 3. (b) If veteran, name war No
 3. (c) Social Security No. N.D.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 18
 year 1946 hour _____ minute 1:30 P.M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (c) Age of husband or wife if alive 6 years
 7. Birth date of deceased: Feb 6 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-16, 1946 to 12-17, 1946
 that I last saw him alive on 12-17, 1946
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>10</u>	<u>12</u>	hr. _____ min. _____

Immediate cause of death _____
 Due to Pneumonia to chronic asthma (cardiac)
 Other conditions (include pregnancy within 3 months of death) _____
 Duration _____

9. Birthplace West Plains Mo.
(City, town, or county) (State or foreign country)
 10. Usual occupation West Plains Mo.

Major findings: _____
 Of operations _____
 Of autopsy _____
 ADDITIONAL PHYSICIAN SUPPLEMENTARY INFORMATION REQUESTED

11. Industry or business Housewife
 12. Name Wm Campbell
 13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
 14. Maiden name Ellen Barnes
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Herry Muller
 (b) Address Cuba, Mo, R.R. #3
 17. (a) Interment (b) Date thereof 1-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Rock Creek Cem.

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 _____

18. (a) Signature of funeral director Shirley Ann Smith
 (b) Address Cuba, Mo.
 19. (a) 12-17-47 (b) Paul A. Thomas
(Date received local registrar) (Registrar's signature)

23. Signature Dr. Glenn Newcomer
 Address Cuba, Mo. Date signed 12-20-46

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

7070

Handwritten notes at the top of the page, including what appears to be a name and a number.

Handwritten notes on the left side of the page.

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed

Handwritten signature of the licensed embalmer.

Licensed Embalmer No. *3472*

P. O. Address *Cuba, D.D.*

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. *Handwritten notes at the bottom right.*

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3-45
K43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7-1
Registrar's No. 4

Registration District No. 86 Primary Registration District No. 5222

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town 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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME

Emma Muller

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 Feb 6 1946
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days _____ If less than one day _____ hr. _____ min.

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 _____, 19____, to _____, 19____; that I last saw him _____, alive on _____, 19____; and that death occurred on the date and hour stated above. _____
immediate cause of death _____

Duration

Due to Bronchial Pneumonia

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed 1-31-47

SUPPLEMENTARY

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

42253

S-43445