

S. No. 2
4-8-43
5-17-39
1-37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 547

FILED FEB 10 1947

Registration District No. _____

Primary Registration District No. 4107

Registrar's No. 5

1. PLACE OF DEATH

(a) County Cedar
(b) City or town Osborne Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3
(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 Mo (b) County Vermon
(c) City or town Schell City
(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 Jan day 26th
year 1947 hour 4 minute 45 P.M.
21. I hereby certify that I attended the deceased from Sept 15th 1946 to Jan 26 1947
that I last saw her alive on Jan 25 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis
Duration _____

Due to _____
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? _____

(Specify type of place)
While at work _____ (2) Means of injury 2
23. Signature [Signature] (M. D. or other) MD
Address El Dorado Spg. Mo. Date signed 1-26-47

3. (a) PRINT FULL NAME Libbie Wasson
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 Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased Jan 30 1863
(Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days 26
If less than one day _____ hr. _____ min.

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

10. Usual occupation House Keeper

11. Industry or business _____

MOTHER FATHER { 12. Name John Wasson
13. Birthplace Scotland 4
(City, town, or county) (State or foreign country)
14. Maiden name Amanda Blackwell 5
15. Birthplace Shelburne Co. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Velah Hunt Chapin
(b) Address Appleton City, Mo.

17. (a) Burial (b) Date thereof Jan 27 47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Blackwell cemetery

18. (a) Signature of funeral director [Signature]
(b) Address Appleton City, Mo.

19. (a) 1/27/47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

67-51-2
at 11-1
L 2

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..... *Oscar Eckhoff*

Licensed Embalmer No..... *3942*

P. O. Address..... *Appleton City, W.*

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.