

U. S. No. 2
FORM-8-43
Rev. 5-17-39
1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4182**
Registrar's No. **65-**

FILED FEB 25 1947
Registration District No. **77**

Primary Registration District No. **3008**

14
1
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County **Ballaway**
(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **State Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **104-5M-11D**
In this community **104-5M-11D**
(Specify whether years, months or days)

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

3. (a) PRINT FULL NAME **Anna Mitchell**
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 **DK**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **DK**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **13th** year **1947** hour **9:25** minute **P.** M.
21. I hereby certify that I attended the deceased from **2-11-47**, 19____, to **2-13-47**, 19____;
that I last saw her alive on **2-13**, 19____, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
75 (around) hr. min.
9. Birthplace **DK** **9**
(City, town, or county) (State or foreign country)

Immediate cause of death **Chronic myocarditis**
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations **93D**
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name **DK** **9**
13. Birthplace **DK** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **DK**
15. Birthplace **DK** **9**
(City, town, or county) (State or foreign country)
16. (a) Informant **Hospital Records**
(b) Address **Fulton, Mo**
17. (a) **Columbiana** (b) Date thereof **15-47**
(City or town) (Month) (Day) (Year)
(c) Place: burial or cremation **Columbiana**
18. (a) Signature of funeral director **J. O. Roberts**
(b) Address **Columbiana**
19. (a) **2-13-1947** (b) **Joan Morsuekoff**
(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 **J P Rize** (M.D. or other) **M.D.**
Address **Fulton, Mo.** Date **2-14/47**

by **A. Fungo**

RECEIVED
District Health Officer No. 9,
District File Number
Filed FEB 25 1947

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.....

Licensed Embalmer No.....

P. O. Address.....

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.