

S. No. 2  
M-8-43  
V. 5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
U.S. GOVERNMENT PRINTING OFFICE: 1947  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4184

State File No. \_\_\_\_\_  
Registrar's No. 90

Registration District No. 77 Primary Registration District No. 3008

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

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Fulton  
(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 7M-1d 2  
In this community Life years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Callaway  
(c) City or town Fulton  
(If outside city or town limits, write "RURAL")  
(d) Street No. R#4 (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Hattie Oliver  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month MAR. day 12 year 1947 hour 12:30 minute P. M.  
21. I hereby certify that I attended the deceased from 12-1- 1946 to 3-2- 1947  
that I last saw her alive on 3-2- 1947  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, 2 divorced widower  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: MAR. 7 1868  
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis Duration Months  
Due to Generalized arteriosclerosis YRS  
Due to Senility YRS  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 93D  
Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
78 11 23 hr. \_\_\_\_\_ min.

9. Birthplace Callaway County, Mo. (City, town, or county) (State or foreign country) 11  
10. Usual occupation Nurse keeper

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Wm. M. Ferguson  
13. Birthplace Virginia (City, town, or county) (State or foreign country)  
14. Maiden name Sadie Diver  
15. Birthplace Virginia (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
(c) 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 D  
23. Signature J. B. Stokes, M.D. (M. D. or other)  
Address Fulton Date signed 3-2-47

16. (a) Informant Mrs. Lon E. Boyer  
(b) Address Fulton, Mo. R#4  
17. (a) Burial (b) Date thereof Mar. 3, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Aux. Home  
18. (a) Signature of funeral director Glen Mangin  
(b) Address 712 Cant Fulton, Mo.  
19. (a) Mar. 4 - 1947 (b) Jose Morosoff  
(Date received local registrar) (Registrar's signature)

NOV 17 1947

RECEIVED  
District Health Officer No. 9,  
District File Number 3-26-47  
Date Filed

NOV 17 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 Glen Y. Manspin  
Licensed Embalmer No. 2725  
P. O. Address Fulton 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.**