S. No. 2
0M—5-43
v. 5-17-39
1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4664

Registration District No. 141 — Primary Registration District No. 3025 — Registrar's No. 33

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains
(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 Mo (b) County Howell
(c) City or town Pomona
(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 .....

3. (a) PRINT FULL NAME Samantha Andrews
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 W

6. (b) Name of husband or wife J. H. Andrews
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased 8 (Month) — 31 (Day) — 1869 (Year)

8. AGE: Years 86 | Months 4 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace (City, town, or county) ..... (State or foreign country) Tenn.
10. Usual occupation Housewife
11. Industry or business .....
FATHER
12. Name Isaach Rose
13. Birthplace (City, town, or county) ..... (State or foreign country) Tenn
MOTHER
14. Maiden name Cook
15. Birthplace (City, town, or county) ..... (State or foreign country) Tenn
16. (a) Informant W. M. Dolins
(b) Address Pomona, Mo
17. (a) B (Burial, cremation, or removal) (b) Date thereof 1-11-47 (Month) (Day) (Year)
(c) Place: burial or cremation Hoy Creek
18. (a) Signature of funeral director Robertson
(b) Address West Plains Mo
19. (a) Feb 17-47 (Date received local registrar) (b) Beatrice Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 1 day 9 year 1947 hour 9 minute a M.
21. I hereby certify that I attended the deceased from 1-8 1947, to 1-9 1947; that I last saw her alive on Jan. 8 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death General Senility	
Due to Old age	
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? ~ (e) Means of injury ~

23. Signature T. A. Baltz M.D. (M. D. or other)
Address Pomona, Mo. Date signed 1-20-1947

519 (Licensed Embalmer's Statement on Reverse Side) Baltz

RECEIVED
District Health Officer No. 6,
District File Number 24718
Date Filed 2-28-47

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 A D Roberts

Licensed Embalmer No. 345

P. O. Address West Plains 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.