

No. 2  
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2-16-62  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 29 1947

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7711  
Registrar's No. 67

Registration District No. 1 Primary Registration District No. 3000

1. PLACE OF DEATH:  
(a) County ADAIR  
(b) City or town KIRKSVILLE  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
COMMUNITY NURSING HOME # 14  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 days  
(Specify whether  
In this community  
years, months or days)

3. (a) PRINT FULL NAME MARY D. CLAIR  
(b) If veteran, name war \_\_\_\_\_ (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 alive \_\_\_\_\_ years  
7. Birth date of deceased 12 20 1874  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 2 26 hr. min.

9. Birthplace MENDON ILLINOIS  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEKEEPER

11. Industry or business \_\_\_\_\_  
12. Name JOHN CLAIR  
13. Birthplace GERMANY  
(City, town, or county) (State or foreign country)  
14. Maiden name SLEA MAR JENKINS  
15. Birthplace IRELAND  
(City, town, or county) (State or foreign country)

16. (a) Informant L. W. HEISEL  
(b) Address BRUNSWICK, MISSOURI  
17. (a) Burial (b) Date thereof 2-18-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation BRUNSWICK, MO.

18. (a) Signature of funeral director L. W. Heisel  
(b) Address Brinswick, Mo.  
19. (a) 3-16-47 (b) Kate Lambert  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Charlton  
(c) City or town Mendon  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16  
year 1947 hour 10 minute 23 A.M.  
21. I hereby certify that I attended the deceased from Feb 27  
1947 to March 16, 1947.  
that I last saw him alive on March 16, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death: Congestive Heart Failure Duration 3 days  
Due to Right Ventricular Failure Months  
Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations: AGE  
Of autopsy: \_\_\_\_\_

Duration  
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 2  
23. Signatur M. T. Lutenash (or other) Dr.  
Address Kirksville, Mo. Date signed 3-16-47

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

APR 9 1947

RECEIVED  
District Health Officer No. 1  
District No. 3-4735  
Date Filed MAR. 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 L. M. Marsal  
Licensed Embalmer No. 823  
P. O. Address Breunswald

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, above space should be left blank.

*April 67*

Registration District No. 1

Primary Registration District No. 2000

Registrar's No.

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirkville  
(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

3. (a) PRINT FULL NAME Mary D. Clair

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Nov 20 (Month) (Day) (Year)

8. AGE: Years 72 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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)

(c) Place: burial or cremation \_\_\_\_\_

18. (c) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 4-9-47 (b) Kate Lambert  
(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 Mar year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. \_\_\_\_\_  
Duration \_\_\_\_\_  
Immediate cause of death \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-7711