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DEPARTMENT OF COMMERCE.
BUREAU OF THE CENSUS

FILED APR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12373
Registrar's No. 62

Registration District No. 0

Primary Registration District No. 3002

1. PLACE OF DEATH:

(a) County ANDRAIN
(b) City or town MEXICO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ANDRAIN HOS. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS
(Specify whether

In this community _____
years, months or days)
3. (a) PRINT FULL NAME ELLA NORTON
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife UNKNOWN 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased SEPT. 27, 1855
(Month) (Day) (Year)

8. AGE: Years 91 Months 6 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation WIDOW

11. Industry or business _____

12. Name JAMES MIDDLEAGE

13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace DK (City, town, or county) (State or foreign country) 9

16. (a) Informant HOSPITAL RECORD

(b) Address MEXICO, MO

17. (a) BURIAL (b) Date thereof 4-14-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELMWOOD, MO

18. (a) Signature of funeral director Chas. Arnsdorf

(b) Address W. H. Arnsdorf

19. (a) 4-14-47 (b) Blanche Neely
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ANDRAIN
(c) City or town MEXICO (If outside city or town limits, write "RURAL") 1
(d) Street No. 433 W. VINE (If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12 year 1947 hour 1 minute _____
21. I hereby certify that I attended the deceased from April 9 1947 to April 12 1947 that I last saw her alive on April 12 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Shock, traumatic Duration _____
Due to fracture of hip 10:15 A
Due to _____ 10:15 A

Other conditions Information of age - 74
(Include pregnancy within 3 months of death)

Major findings: fracture of hip (female)
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death is charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION

22. If death was due to external causes, fill in the following: (M.F.) (M.D.) (M.S.) (M.A.) (M.P.) (M.C.) (M.O.)
(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) (d) Means of injury _____

23. Signature W. Kallenbach (M. D. or other) _____
Address 119 E. Jackson Mexico Date signed April 23, 1947

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 447698
Date Filed APR 22 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 Chas. Amundson Jr

Licensed Embalmer No. 3569

P. O. Address Missis, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registral's No. 628

Registration District No. 10 Primary Registration District No. 3002

1. PLACE OF DEATH:

(a) County Anderson
(b) City or town Mexico
(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) (Specify whether

3. (a) PRINT FULL NAME Ella Norton

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 wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Sept 27 (Month) (Day) (Year)

8. AGE: Years 91 Months 6 Days _____ (Unless than one day) hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) D.K.

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (City, town, or county) (State or foreign country)
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 _____ year 1944 hour _____ minute _____ M. 12

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

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident ✓

(b) Date of occurrence April 9 1947

(c) Where did injury occur? Mexico (City or town) Anderson (County) MO (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? no (Specify type of place) (e) Means of injury Self (fall)

23. Signature M. Kallenbach (M. D. or other)

Address 1196 Graham Date signed 4-28-47

SUPPLEMENTARY

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

12373