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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 18 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14301
3
Registrar's No.

Registration District No. 228
Primary Registration District No. 5808

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Rural
(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 Life (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Anna C. Camp
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 _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 23rd 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 6 13 _____ hr. _____ min.

9. Birthplace High Hill Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER

12. Name F.M. Craig
13. Birthplace Montgomery CO
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Fullington
15. Birthplace Rhineland Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Frankie Livings
(b) Address New Florence Mo

17. (a) Burial (b) Date thereof 4-8-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Pleasant Cem

18. (a) Signature of funeral director C. W. Hopkins

(b) Address Montgomery City Mo

9. (a) April 7-47 (b) Mrs May Miller
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Montgomery
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 4 miles east New Florence Mo
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 6
year 1947 hour I minute _____ P.M.
21. I hereby certify that I attended the deceased from April 6
8 19 47 April 6 19 47
that I last saw h. or alive on April 6
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration 7hrs.

Due to Hypertension and arteriosclerosis 337 Sev. Yrs.

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

Major findings:
Of operations None performed
Of autopsy None performed
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

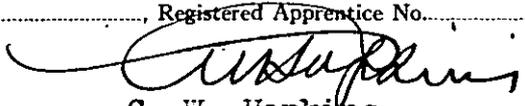
23. Signature C. H. Thompson (M. D. or other) DO
Address New Florence, Mo Date signed 4/7/47

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 4-8-47

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..... on the 6th
day of April 1947....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

C. W. Hopkins

Licensed Embalmer No. 1487

P. O. Address. Montgomery City 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.