

FILED MAY 12 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14559

State File No. _____

Registration District No. 287

Primary Registration District No. 5974

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Goodson
(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 Missouri (b) County Polk
(c) City or town Goodson
(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 Jesse Elizabeth Rush

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 25 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 1 15 hr. _____ min.

9. Birthplace Polk County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Jessie Richardson

13. Birthplace Polk County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Stewart

15. Birthplace Polk County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Linnie Kee

(b) Address Louisburg, Mo.

17. (a) burial (b) Date thereof Apr. 16 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lindley Creek Cemetery

18. (a) Signature of funeral director Turpin Funeral Home

(b) Address Bohler, Mo.

19. (a) 4 23 1947 (b) W. J. Zinnwald, Reg.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1947 hour 4 minute 45 P.M.

21. I hereby certify that I attended the deceased from 1941
to April 10, 1947
that I last saw her alive on 4-10-47
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration _____

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 W. J. Zinnwald, Reg.

Address Bohler, Mo. Date signed 7-11-47

RECEIVED
District Health Officer No. 71
47-547
District File Number 5-9-47
Date Filed

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.

Signed.....

.....
Licensed Embalmer No. 5053

P. O. Address..... Bolivar, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

State File No. May
Registrar's No. 28

Registration District No. 284

Primary Registration District No. 597X

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Goodman
(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 _____ (Specify whether _____)
years, months or days

3. (c) PRINT FULL NAME

Jesse E. Rush

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 _____ month _____ day

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 84 Months 1 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 housewife

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)
(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 194 hour _____ minute _____ M.

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

Duration

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 _____

SUPPLEMENTARY

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

14539