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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JUN 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16740  
State File No.

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 202

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton

(c) Name of hospital or institution: State Hospital No. 1. 2.  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 43 year 5 M.  
(Specify whether years, months or days) same.

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon 14

(c) City or town Macon.  
(If outside city or town limits, write "RURAL") 1

(d) Street No. \_\_\_\_\_  
(If rural, give location) 2

(e) Citizen of foreign country? NO. (Yes or No) U

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME IDA. M. STREIGHT.

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 S. (1)

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: D.K.  
(Month) (Day) (Year)

8. AGE: Years 69 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace U.S.A.  
(City, town, or county) (State or foreign country) 4

10. Usual occupation none.

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name D.K.

13. Birthplace D.K.  
(City, town, or county) (State or foreign country) 7

14. Maiden name D.K.

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

16. (a) Informant: Hospital Records

(b) Address Fulton Mo.

17. (a) Removal. (b) Date thereof 5-28-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Safe Chapel

18. (a) Signature of funeral director John F. ...

(b) Address Macon Mo.

19. (a) 5-28-1947 (b) Joey M. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28  
year 1947 hour 7 minute 20 A. M.

21. I hereby certify that I attended the deceased from 5-25-47 19... to 5-28-47 19...  
that I last saw h. ER alive on 5-27-47 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Chronic Myocarditis.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Spinal injury fracture hip  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
Of autopsy 16 14

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) \_\_\_\_\_ 14 ✓

(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 \_\_\_\_\_

Signature R. P. Price (M. D. or other) M.D.

Address Fulton Mo. Date signed 5/28/47

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

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed JUN 3 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 C. L. Stephens  
Licensed Embalmer No. 3057  
P. O. Address Macon, 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

## 1. PLACE OF DEATH:

(a) County Callaway  
 (b) City or town Fulton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
State Hospital No 1.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 43 years  
 In this community same. (Specify whether  
 years, months or days)

3. (a) PRINT  
FULL NAME3. (b) If veteran,  
name war3. (c) Social Security  
No.

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

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

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

8. AGE: Years Months 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

12. Name D.R.  
 13. Birthplace D.R.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name D.R.  
 15. Birthplace D.R.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records  
 (b) Address Fulton Mo.  
 17. (a) (Burial, cremation, or removal) (b) Date thereof  
 (Month) (Day) (Year)

(c) Place: burial or cremation  
 18. (a) Signature of funeral director Stephens + Gooding  
 (b) Address Macon Mo.  
 19. (a) (Date received local registrar) (b) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon  
 (c) City or town macon.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. (If rural, give location)  
 (e) Citizen of foreign country? NO. (Yes or No)  
 If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 28  
 year 1947 hour 7:30 minute PM

21. I hereby certify that I attended the deceased from  
 that I last saw him alive on 5-28-47  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death chronic myocarditis

Duration

Due to  
 Due to

Other conditions  
 (include pregnancy within 3 months of death)

Major findings:  
 Of operations

Of autopsy same.

## PHYSICIAN

Underline  
 the cause to  
 which death  
 should be  
 charged sta-  
 tistically.

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

(a) Accident, suicide, or homicide (specify) fracture Hips  
 (b) Date of occurrence May 28/1947  
 (c) Where did injury occur? fell out of bed  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
State Hospital No 1.  
 (Specify type of place)  
 While at work? (e) Means of injury

23. Signature J.P. Price (M.D. or Other)  
 Address Fulton Mo. Date signed 5/28/47  
by H. H. Mayo MD.

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

SUPPLEMENTARY

16740  
June  
202

16740