

No. 2
DOM-5-43
Rev. 5-17-39
I X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18337**
Registrar's No. **180**

FILED MAY 19 1947

Registration District No. **2** Primary Registration District No. **3052**

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

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bathwell Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 min
(Specify whether years, months or days)

In this community Ruth Ann

3. (a) PRINT FULL NAME. Infant son of Ruth Ann & Victor McFadden

3. (b) If veteran, name war: _____ 3. (c) Social Security No: _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased: May 7 1947
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. <u>30</u> min.

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

10. Usual occupation: _____

11. Industry or business: _____

MOTHER FATHER

12. Name Victor A. McFadden

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

14. Maiden name Ruth Ann Slane

15. Birthplace Sedalia Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Victor McFadden

(b) Address 1020 So. Lamine, Sedalia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-47
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director McLaughlin Bros

(b) Address Sedalia, Mo

19. (a) 5-8-47 (Date received local registrar) (b) Betty Yeager (Registrar's signature)
(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis

(c) City or town Sedalia
(If outside city or town limits, write "RURAL")

(d) Street No. 1020 So. Lamine
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7
year 1947 hour 8 minute 35 P M.

21. I hereby certify that I attended the deceased from 5-7-47 to 5-7-47
that I last saw him alive on 5-9-47
and that death occurred on the date and hour stated above.

Immediate cause of death: Asphyxia

Due to: Placenta Praevia Centralis

Due to: _____

Other conditions: Immaturity
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations: _____

Of autopsy: He

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) _____

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 JM Rodeman (M. D. or other) MD
Address Sedalia Mo Date signed 5-8-47

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 5-16-17.....

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 RP McLeary.....

Licensed Embalmer No. 3153.....

P. O. Address Sudalia 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.