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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 9 1947

Registration District No. 314

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25197

Primary Registration District No. 6063

Registrar's No.

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

1. PLACE OF DEATH:
(a) County St. Clair
(b) City or town Iconium (Rural) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 17
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community One Month (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cole 26
(c) City or town Jefferson City 5
(If outside city or town limits, write "RURAL")
(d) Street No. 4
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Augusta M. Party

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife August Party

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

7. Birth date of deceased June (Month) 6 (Day) 1881 (Year)

8. AGE: Years 66 Months 0 Days 29 If less than one day hr. min.

9. Birthplace Bonnets Mill (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Housekeeping

11. Industry or business

MOTHER FATHER

12. Name Jule Henriot 5

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

14. Maiden name Unknown 9

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

16. (a) Informant George Cain
(b) Address Iconium Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-8-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Maty's Cemetery

18. (a) Signature of funeral director F.E. Goodrich
(b) Address Osceola Missouri

19. (a) 8-1-1947 (Date received local registrar) (b) Ruth Lewis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5th year 1947 hour 1:14 minute P.M.

21. I hereby certify that I attended the deceased from May 18, 1946, to July 5, 1947, that I last saw her alive on July 3, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Respiratory failure	
Due to Cerebral hemorrhage	2 hrs.
Due to arterial hypertension	unknown
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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature C. F. Edwards (M.D. or other)
Address 2603 Independence Blvd. Date signed 7-6-47
Kansas City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
Number 9-47-920
8-8-47

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 ....., Registered Apprentice No. ....., working under my personal supervision.

Signed F B Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola 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.