

S. No. 2
8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30107**

FILED SEP 3 1947
Registration District No. **28**

Primary Registration District No. **KS-12**

Registrar's No. **32**

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

1. PLACE OF DEATH:

(a) County Sullivan

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

(c) Name of hospital or institution: 1
(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 _____ (b) County 105

(c) City or town _____ (If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0

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

3. (a) PRINT FULL NAME FANNIE ALTISER

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15 year 1947 hour _____ minute 8 A. M.

21. I hereby certify that I attended the deceased from Jan 10, 1940, to Aug 15, 1947, that I last saw her alive on Aug 15, 1947 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife C. L. ALTISER 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased: October 1, 1979
(Month) (Day) (Year)

Immediate cause of death: Cardiac failure
Chronic Myocarditis

Due to _____

Due to _____

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

8. AGE: Years 67 Months 10 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Cowley County, Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

Major findings: Of operations 938

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business _____

12. Name Joseph L. Brackett

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

14. Maiden name Sarah E. Tucker

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

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 Y. A. Dale (M. D. or other) P.O.
Address Newtown Mo Date signed 8/16/47

16. (a) Informant C. L. Altiser

(b) Address Newtown, Missouri

17. (a) Burial (b) Date thereof 8-17-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brackett Cemetery

18. (a) Signature of funeral director Judd & Payne

(b) Address Newtown, Missouri

19. (a) Aug. 27-47 (b) Brita Caldwell
(Date received local registrar) (Registrar's signature)

RECEIVED
District Health Officer No. 10
Dist. No. 9-47-1146
Date Filed SEP 2 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 T. Howard Judd
Licensed Embalmer No. 1240
P. O. Address Newtown

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.