

S. No. 2
M-8-43
7-5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30254**

Registration District No. **9** Primary Registration District No. **3001** Registrar's No. **25**

1. PLACE OF DEATH:
(a) County **P. Audrain**
(b) City or town **Vandalia**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Brown's Nursery Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 wks**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **Pike 82**
(c) City or town **Bowling Green**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **HALLIE M JENSEN**
3. (b) If veteran, name war **X**
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **20th**
year **1947** hour **11** minute **20 P.** M.

4. Sex **Female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Wm Jensen**
6. (c) Age of husband or wife if alive **4** years
7. Birth date of deceased **Apr 28 1868**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **20 MAR 31, 1947** to **Sept 20th 1947**
that I last saw **her** alive on **Sept 20th 1947**
and that death occurred on the date and hour stated above.

8. AGE: Years **74** Months **4** Days **28**
If less than one day hr. _____ min. _____

Immediate cause of death **Chronic myocarditis**
Due to _____
Due to _____

9. Birthplace **Pike Co MO**
(City, town, or county) (State or foreign country)
10. Usual occupation **House wife**

Other conditions **Small dementia, generalized intern-ritusis**
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy **93P**

11. Industry or business _____
12. Name **Thomas Stewart**
13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)
14. Maiden name **Rebecca Mathis**
15. Birthplace **Pike Co MO**
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs Edna Hamlett**
(b) Address **Bowling Green MO**
17. (a) **Burial** (b) Date thereof **9 28 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Grave Cemetery**
18. (a) Signature of funeral director **Grave Cemetery**
(b) Address **Bowling Green MO**
19. (a) **Sept 29 1947** (b) **J. M. Jensen**
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury **0**
23. Signature **J. B. Brown M.D.** (M. D. or other)
Address **Bowling Green MO** Date signed **9/21/47**

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

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JUN 7 1950

RECEIVED
District Health Officer No. 10
District File Number 10-47-1377
Date Filed OCT-8-1947

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 *Grace M. Rankin*

Licensed Embalmer No. *2204*

P. O. Address *Bowling Green, 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.