

No. 2
-12-45
-5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33522

State File No.

Registration District No. 367

Primary Registration District No. 6226

Registrar's No.

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution South West Desfield, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 77 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon 108

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

(d) Street No. South West Desfield, Mo.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Arabella Kaster

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th, year 47 hour _____ minute _____ M.

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Born 12-21-1859
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 27/47 1947 to Sept 27 1947 that I last saw her alive on Had never seen patient and that death occurred on the date and hour stated above.

Immediate cause of death Don't know
as I had not seen her
sent medicine to control

8. AGE: Years 87 Months 11 Days 6 If less than one day _____ hr. _____ min.

Due to Nausea on Sept. 27
Probably myocarditis

Due to _____

9. Birthplace Unknown Iowa
(City, town, or county) (State or foreign country)

Other conditions Don't know
(Include pregnancy within 3 months of death)

MOTHER, FATHER

11. Industry or business _____

12. Name William Taylor

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

14. Maiden name _____

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant P. C. Kaster

(b) Address Desfield, Mo.

17. (a) Rural (b) Date thereof 9-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moines Cem.

18. (a) Signature of funeral director M. B. Exchange

(b) Address Newark, Mo.

19. (a) 10-10-47 (b) Bertha Singl.
(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) (e) Means of injury _____

23. Signature C. M. Love (M. D. or other) _____

Address Merada, Mo Date signed 10/1/47

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

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..... *Marsh Eickinger*
Licensed Embalmer No. *2656*
P. O. Address. *Needles 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.