

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 25 1947
Registration District No. 47

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 365-

Primary Registration District No. 3008

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

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hosp. #1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. Since Aug 15-47
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME George Jeans
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 19 1858
(Month) (Day) (Year)

8. AGE: Years 89 Months 5 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name B.K. 9
13. Birthplace B.K. (City, town, or county) (State or foreign country)
14. Maiden name B.K.
15. Birthplace B.K. (City, town, or county) (State or foreign country)

16. (a) Informant in complete hosp. record
(b) Address _____

17. (a) BURIAL (b) Date thereof OCT 16 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation TROY, MO

18. (a) Signature of funeral director Temp General Home
(b) Address Troy, Mo.

19. (a) Oct 14 1947 (b) Josie Morsink
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Lincoln 14
(c) City or town Troy 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 13
year 1947 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from Aug 15, 1947, to Oct 13, 1947
that I last saw him alive on Oct 13, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis heart disease

Due to _____

Due to _____

Other conditions Hypertatic Pulmonary
(Include pregnancy within 6 months of death)
congestion

Major findings: 95P
Of operations _____
Of autopsy _____

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 J. C. Caldwell (M. D. or other)

Address State Hosp #1 Date signed 10-13-47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 10-24-47

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..... *Joseph J. Marsh*.....

Licensed Embalmer No. *3932*.....

P. O. Address..... *Troy, Missouri*.....

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.