

No. 2
-1/47
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34956**
Registrar's No. **46**

FILED NOV 3 1947
Registration District No. **26**

Primary Registration District No. **8-68-8**

1. PLACE OF DEATH:
(a) County **Lawrence**
(b) City or town **rural Vineyard**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route 1, LaRussell
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **20 years**
(Specify whether years, months or days)

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

3. (a) PRINT FULL NAME **MAUD B. ROYSTER**
3. (b) If veteran, name war **none**
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **20**
year **1947** hour **6** minute **15** M.

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Frank Royster**
6. (c) Age of husband or wife if alive **73** years
7. Birth date of deceased **March 28 1894**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 20 1947** to **October 20 1947**
that I last saw **her** alive on **October 19 1947**
and that death occurred on the date and hour stated above.
Duration

8. AGE: Years **53** Months **6** Days **28**
If less than one day hr. min.

Immediate cause of death
acute bronchial asthma

9. Birthplace **Wright County Missouri**
(City, town, or county) (State or foreign country)

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **housewife at home**

Major findings:
Of operations
Of autopsy

MOTHER FATHER
12. Name **unknown**
13. Birthplace **unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause of which death should be charged statistically.
112

16. (a) Informant **Venita Royster**
(b) Address **Route 1, LaRussell, Mo**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence

17. (a) **burial** (b) Date thereof **Oct 22, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Thomas Cemetery**

(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)

18. (a) Signature of funeral director **Knell Mortuary**
(b) Address **Carthage, Missouri**

While at work? (Specify type of place)
(e) Means of injury

19. (a) **10-22-47** (b) **W. S. [Signature]**
(Date received local registrar) (Registrar's Signature)

23. Signature **P. A. Holmes** (M. D. or other)
Address **mt Vernon, Mo** Date signed **10-22-47**

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

Health Officer No. 6,

Number _____

RECEIVED.

District Health Officer No. 6;

District File Number 1047-1142

Date Filed OCT 31 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 _____

Robert H. Knell

Registered Apprentice No. 406

working under my personal supervision.

Signed _____

Frank W. Knell Jr

Licensed Embalmer No. 4440

P. O. Address Carthage

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.