

No. 2
43
7-39
X37823

FILED DEC 3 1947
Registration District No. 0

Primary Registration District No. 3002

State File No. _____
Registrar's No. 169

1. PLACE OF DEATH:

(a) County RUDRAIN.

(b) City or town MEXICO, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
RUDRAIN CO. HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 MO. (Specify whether _____)

In this community St. Joseph
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County RUDRAIN.

(c) City or town MARTINSBURG-MO.
(If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

3. (a) PRINT FULL NAME Margaret-Washington-Torreyson

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 31
year 1947 hour 7:30 minute _____ P.M.

21. I hereby certify that I attended the deceased from 4-5 1946 to 10-31 1947
that I last saw h. _____ alive on 10-31-47 19____
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 SINGLE

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

7. Birth date of deceased: February 22 1863
(Month) (Day) (Year)

Immediate cause of death Choleo Nephritis

Due to Hypertension

Due to _____

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

8. AGE: Years Months Days If less than one day

84 8 9 _____ hr. _____ min.

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation SCHOOL-TEACHER.

11. Industry or business SCHOOL.

MOTHER FATHER

12. Name John Torreyson

13. Birthplace CUIVER Township, MO
(City, town, or county) (State or foreign country)

14. Maiden name Unkown

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

16. (a) Informant Mrs. James Inman.

(b) Address LADDONIA-MO.

17. (a) BURIAL (b) Date thereof 11-2 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LADDONIA-MO.

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? _____

18. (a) Signature of funeral director Clyde C. Willey

(b) Address LADDONIA-MO.

19. (a) 11/24/47 (b) Blanche Neely
(Date received local registrar) (Registrar's signature)

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

23. Signature Frank Kelley (M. D. or other) M. D.

Address Mexico, Missouri Date signed 11/24/47

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

RECEIVED
District Health Officer No. 10
District File Number 12-47-1648
DEC - 21 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.....

John F. Egan....., Registered Apprentice No. *494*
working under my personal supervision.

Signed *Clyde C. Wilkey*
Licensed Embalmer No. *3820*
P. O. Address *Perry, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. See
Registrar's No. 169

Registration District No. 10 Primary Registration District No. 3002

1. PLACE OF DEATH:
(a) County Andrain
(b) City or town Mexico
(c) Name of hospital or institution:
(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) (Specify whether

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

3. (a) PRINT FULL NAME Margaret W. Jorreyon
3. (b) If veteran, name war..... 3. (c) Social Security No.

20. DATE OF DEATH: Month October year 1947 hour 3 minute 37 M.
21. I hereby certify that I attended the deceased from..... to.....
that I last saw him/her alive on..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....
7. Birth date of deceased Jul 22 (Month) (Day) (Year)

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

8. AGE: Years 84 Months..... Days..... if less than one day
9. Birthplace Andrain, Missouri (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.....

10. Usual occupation.....
11. Industry or business.....
MOTHER FATHER { 12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name (City, town, or county) (State or foreign country)
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.....
18. (a) Signature of funeral director..... (b) Address.....
19. (a) (Date received local registrar) (b) (Registrar's signature)

23. Signature..... (M. D. or other)
Address..... Date signed.....

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

SUPPLEMENTARY

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

S-36977