

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42179**
Registrar's No. **18**

FILED JAN 7 1948

Registration District No. **171**

Primary Registration District No. **5639**

1. PLACE OF DEATH:

(a) County **Lafayette**
(b) City or town **Rural- Washington Twns**
(If outside city or town limits, write "RURAL" and name of township)
(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 **Life** (Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME **Mary Atkinson**

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

4. Sex **Fe** / race **W** 5. Color or _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if divorced **Single**
7. Birth date of deceased **May 15 1861**
(Month) (Day) (Year)

8. AGE: Years **86** Months **2** Days **23**
If less than one day hr. min.

9. Birthplace **Lafayette Co. Mo. 6**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Danuel S. Atkinson**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Ann O. Williams**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Warren McCoy**

(b) Address **Odessa, Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 10, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Tabor Cem. Odessa, Mo.**

18. (a) Signature of funeral director **Husman-parks**
(b) Address **Odessa, Mo.**

19. (a) **Sept. 1-1947** (b) **Walter Drummond**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lafayette 54**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **8 Miles SE of Odessa**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **8** year **1947** hour _____ minute _____ A.M.

21. I hereby certify that I attended the deceased from **Jan 1 1942** to **Aug 3 1947**
that I last saw him alive on **Aug 3 1947**
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Minimal respiration with failing circulation
Choked to death
Due to _____

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

Major findings: Of operations _____ Of autopsy _____
PHYSICIAN Underline the cause to which death should be charged statistically.

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? **Mo.**
(Specify type of place) _____ Means of injury _____

23. Signature **Walter Drummond** (M. D. or other) **8/19/47**
Address **Odessa Mo.** Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-5-48

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

Irving E. Husner

Licensed Embalmer No.

7541

P. O. Address

Adm. Bldg.

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.