

No. 2  
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DK37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 11 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1890

State File No. ....

Registration District No. 247

Primary Registration District No. 5840

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Newton

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

(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

- In this community \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73

(c) City or town Ritchey, Mo. 0  
(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 Rufus Allen Christain

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2  
year 1948 hour 5 minute 27P.M.

4. Sex Male ( ) 5. Color or race W.

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

6. (b) Name of husband or wife Dossie Christain

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased September 20 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 2, 1947, to Dec. 31, 1947 that I last saw him alive on Dec 31, 1947 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>3</u>	<u>13</u>	hr. _____ min. _____

Immediate cause of death Septicemia

Due to Psoas Abscess

Duration 9 days

2 Mo.

9. Birthplace \_\_\_\_\_ Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Section Labor & Flagman

11. Industry or business \_\_\_\_\_

Due to Spinal curvatures  
etiology undetermined

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

2 Mo.

MOTHER FATHER

12. Name John Christain

13. Birthplace Ill. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Jane Hunter

15. Birthplace Not Known 9  
(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 Mrs Dossie Christain

(b) Address Ritchey, Mo.

17. (a) Burial (b) Date thereof 1-6-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson, 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 Wm. M. Young

(b) Address Wheaton, Mo.

19. (a) 2-16-48 (b) M. L. Young  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 2

23. Signature Wm. M. Young (M.D. or other) DO

Address Granby Mo. Date signed 1-7-48

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

FEB 20 1948

RECEIVED

District Health Officer No. Newton  
District File Number 248-244  
Date Filed 2-10-48

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 Wm. Morris Dyer

Licensed Embalmer No. 34429

P. O. Address Wheaton, 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.

Registration District No. *247*

Primary Registration District No. *W-840*

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County *Newton*  
 (b) City or town *Ritchey*  
(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 \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME *Refus A. Christian*

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

4. Sex *m* 5. Color on race *w* 6. (a) Single, widowed, married, divorced *m*

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

7. Birth date of deceased *Sept 20 1942*  
(Month) (Day) (Year)

8. AGE: Years *72* Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) *2-16-1944* (b) *M L Young*  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year *1944* Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

S - 1890