No. 2
M—5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 11 1948

Registration District No. 86

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5328

State File No. 11968

Registrar's No. 17-1948

1. PLACE OF DEATH:

(a) County: Crawford

(b) City or town: Rural Liberty Twsp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bourbon, Mo. Star Rt.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 (Specify whether years, months or days)

In this community: Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Crawford 28

(c) City or town: Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No.: Anthonies Mill, Mo. 0
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0

If yes, name country:

3. (a) PRINT FULL NAME: Della May Isgrig

3. (b) If veteran, name war: xx

3. (c) Social Security No.: None

4. Sex: 1 Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: 2 Widowed

6. (b) Name of husband or wife: Walter Isgrig

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

7. Birth date of deceased: March (Month) 29 (Day) 1877 (Year)

8. AGE: Years 71 | Months 0 | Days 25 | If less than one day: hr. min.

9. Birthplace: Anthonies Mill, (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER
12. Name: John Harmon
13. Birthplace: Anthonies Mill, Mo. 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Fannie Pratt
15. Birthplace: Anthonies Mill, Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant: Willard Isgrig

(b) Address: Anthonies Mill, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 25/48 (Month) (Day) (Year)

(c) Place: burial or cremation: Anthonies Mill, Mo.

18. (a) Signature of funeral director: [illegible]

(b) Address: Sullivan, Mo.

19. (a) 4-24-48 (Date received local registrar) (b) [illegible] 5/2

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23 year 1948 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 8, 1948, to, 19..; that I last saw her alive on April 16, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: advanced arteriosclerosis	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: 97	

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Ronald N. Scott (M.D. or other)

Address: Bourbon Date signed: 4/23/48

RECEIVED
District Health Officer No 5
District File Number 548299
Date Filed 5-8-48

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 Robert M. Murray
Licensed Embalmer No. 3749
P. O. Address Sullivan, 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.