

No. 2  
5-43  
17-39  
X36871

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 28 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15309

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 3000

Registrar's No. 148

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution:  
Community Nursing Home #2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days  
(Specify whether)

In this community 40 years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon

(c) City or town La Plata  
(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 Martha Maria Grear

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14  
year 1948 hour 3 minute 40 A.M.

21. I hereby certify that I attended the deceased from May 2  
1948 to May 14 1948  
that I last saw her alive on May 14 1948  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife Edward Grear

6. (c) Age of husband or wife alive 77 years

7. Birth date of deceased Sept 28 1975  
(Month) (Day) (Year)

Immediate cause of death Loxemia Duration 19 days

Due to Intestinal obstruction 19 days

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

72 7 16 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business Retired

12. Name Charles Pruet

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Etta Filmer

(b) Address La Plata Mo.

17. (a) Burial (b) Date thereof May 16 - 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La Plata Mo

18. (a) Signature of funeral director Donnet M. Wilson

(b) Address La Plata, Mo.

19. (a) 5-18-48 (b) Walter Lambert  
(Date received local registrar) (Registrar's signature)

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. T. Hutchins (M. D. or other) MD  
Address Kirksville, Mo Date signed 5-14-48

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

MOTHER FATHER

RECEIVED  
District Health Officer N  
District File Number 5-48  
Date Filed MAY 26 1948

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.....

Bennett M. Wilson  
working under my personal supervision.

Registered Apprentice No. 204

Signed.....

George D. Barber  
Licensed Embalmer No. 1817

P. O. Address.....  
Wyandotte

**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. juis  
Registrar's No. 148

Registration District No. 1 Primary Registration District No. 3000

1. PLACE OF DEATH:  
(a) County Adair  
(b) City or town Hubbards  
(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

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May 1948 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

4. Sex F 5. Color or 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 \_\_\_\_\_ months \_\_\_\_\_ days

Immediate cause of death cause unknown  
Dup to autopsy refused  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 72 Months 7 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) MO

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

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)

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 \_\_\_\_\_

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

23. Signature M.T. Hutchinson (M.D. or other) \_\_\_\_\_  
Address Hubbards, Mo. Date signed 6-9-48

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

SUPPLEMENTAL

S-15309