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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 2 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17307

Registration District No. 814

Primary Registration District No. 6664459

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 80 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway

(c) City or town Osceola
(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 Frances Durr Hook

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F-1 5. Color or race W 6. (a) Single, widowed, divorced, married

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

7. Birth date of deceased August 4 1860
(Month) (Day) (Year)

8. AGE: Years 87 Months 8 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name George Durr

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

14. Maiden name Barbara Hart

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

16. (a) Informant Mrs. Glen Tolson
(b) Address Osceola Missouri

17. (a) Burial (b) Date thereof April 7, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Yellcrest - Fulton, Mo

18. (a) Signature of funeral director F. B. Goodrich
(b) Address Osceola Mo

19. (a) 4-5-1948 (b) Paul Severs
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5
year 1948 hour 12 minut noon M.

21. I hereby certify that I attended the deceased from 1-15-48
4-5, 1948 to _____, 19____;

that I last saw her alive on 4-5, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia

Due to malignancy in breast

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 50

Of autopsy _____

Duration 8 mo.

5 yrs.

22. If death was due to external causes, fill in the following:

(c) 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 _____ (c) Means of injury _____

23. Signature Ruth Severs (M. D. or other) _____
Address Osceola Mo Date signed 4-5-48

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

JUN 16 1948

JUN 4 1948

RECEIVED
District Health Officer No. 7
District File Number 5-48-58
Date Filed 6-1-48

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 J. B. Goodrich
Licensed Embalmer No. 3038
P. O. Address Presque Isle

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. June

Registration District No. 314

Primary Registration District No. 4459

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Clair

(b) City or town Osceola
(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 Francis D. Hook

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

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 _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1947 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.

Immediate cause of death _____

Due to malignancy of breast - of a

Due to carcinomatous type

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

Major findings: Of operations _____

Of autopsy _____

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 Keith Secor (M. D. or other) _____

Address _____ Date signed 6-10-47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

S-17307