

FILED AUG 11 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25176

State File No. _____

Registration District No. 370

Primary Registration District No. 6151

Registrar's No. 48

1. PLACE OF DEATH

(a) County Stoddard
(b) City or town Parma, Mo. R I
(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 _____)
In this community 3 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
(c) City or town 6 mi North of Parma
(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 ELLA-C-MASON

3. (b) If veteran, name war NO 3. (c) Social Security No. None

4. Sex F 5. Color of hair White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Husband dead 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days 18 If less than one day hr. min.

9. Birthplace Portico Miss. (City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business _____

12. Name unknown

13. Birthplace unknown (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 Hugh Yarnest

(b) Address Parma Mo R I

17. (a) burial (b) Date thereof 7-24-48 (Month) (Day) (Year)

(c) Place: burial or cremation Parma Mo

18. (a) Signature of funeral director Walter H. Hume

(b) Address Parma Mo

19. (a) 8-3-48 (Date received local registrar) (b) Elma D Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July, day 21, year 1948 hour 11 minute 15 A.

21. I hereby certify that I attended the deceased from 5-31-48, 19, to 7-21-48, 19, that I last saw him alive on 7-18-48, 19, and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocardial Degeneration

Due to _____

Due to _____

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) (b) Means of injury 2

23. Signature W H Gilson (M. D. or other)

Address Parma Mo Date signed 7-22-48

RECEIVED

District Health Office No. 2,

District File Number 848-1001

Date Filed 8-9-48

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 Lyman Steele

Licensed Embalmer No. 2476

P. O. Address Dexter Ma

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.