

S. No. 2  
M-1/47  
7-5-17-39

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39972

National Office of Vital Statistics

State File No. ....

FILED DEC 20 1948

DECEASED

5552

Registrar's No. 39

Registration District No. 171

Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County ~~Howell~~ HOWELL

(b) City or town ~~Roskruong~~ Roskruong MO  
(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: 74 yrs (Specify whether years, months or days)

In this community: 74 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Howell MO

(c) City or town Roskruong MO  
(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: Karline D. Deuren

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 - day 30 year 1948 hour 2 minute 15 a.m.

21. I hereby certify that I attended the deceased from 5:20 1948 to 7:11 1948 that I last saw her alive on 7/11 1948 and that death occurred on the date and hour stated above.

4. Sex F / race W

5. Color or race W

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

6. (c) Age of husband or wife if alive: 87 3 years

7. Birth date of deceased: Dec 14 - 1873  
(Month) (Day) (Year)

Immediate cause of death: cerebral apoplexy

Due to: chr. interstitial nephritis

Other conditions: .....

Major findings: Of operations: 13/10

Of autopsy: .....

Duration: 12 hrs

PHYSICIAN: .....

Underline the cause of which death should be charged statistically.

8. AGE: Years 74 Months 7 Days 16 If less than one day hr. min.

9. Birthplace: Oregon Co. MO  
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: .....

12. Name: Gno Bates

13. Birthplace: .....

14. Maiden name: .....

15. Birthplace: .....

16. (a) Informant: Eli N. Deuren

17. (a) Address: West Haver MO

18. (a) Signature of funeral director: Robert M. ...

19. (a) Date received local registrar: Dec 9 - 1948 (b) Registrar's signature: Beatrice Cook

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: Maurice Shawyer (M. D. or other M.D.)  
Address: West Plains MO Date signed: 11/27/48

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

46  
30

MOTHER FATHER

RECEIVED 12-14-48  
District Health Officer No. 5,  
District File Number 12-18784  
Date Filed 12-15-48

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 *A. A. Robertson*

Licensed Embalmer No. 3437

P. O. Address West Haven, Conn.

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.