

S. No. 2
OM-8-43
V. 5-17-39
P1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. D.M. Dealbeast
30991

FILED OCT 6 1944

State File No. _____

Registration District No. 13

Primary Registration District No. 5519

Registrar's No. 150

1. PLACE OF DEATH: *White Oak Farm*

(a) County *Henry*

(b) City or town *Wich Rural*
(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 *55 years*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *Henry*

(c) City or town *Wich - 3 M. N.E. 42*
(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 *Parlee C. Ewing*

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *9* day *9*
year *1944* hour *8* minute *30 AM*

5. Color or race *W*

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

6. (b) Name of husband or wife *Lura*

6. (c) Age of husband or wife if alive *55* years

7. Birth date of deceased: *1 - 10 - 1876*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Sept 7* 1944 to *Sept 7* 1944
that I last saw him alive on *Sept 7* 1944
and that death occurred on the date and hour stated above.

Immediate cause of death *Distention of Stomach*

8. AGE: Years *68* Months *7* Days *29*
If less than one day _____ hr. _____ min.

Due to *Influenza*

Due to _____

9. Birthplace *Ohio*
(City, town, or county) (State or foreign country)

10. Usual occupation *Farmer*

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

Major findings: _____

Of operations _____

11. Industry or business _____

12. Name *Peter Ewing*

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

14. Maiden name *Jane ?*

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

Physician _____

Underline the cause to which death should be charged statistically.

16. (a) Informant *Lura Ewing*

(b) Address *Wich Mo*

17. (a) *Burial* (b) Date thereof *9-11-44*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Mullens Cem*

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? _____

18. (a) Signature of funeral director *Fred Wilkerson*

(b) Address *Clinton Mo*

19. (a) *Sept. 11, 1944* (b) *Georgia Kitchen*
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury *?*

23. Signature *J. W. Gulbransen* (M. D. registrar)
Address *Wich Mo* Date signed *9-11-44*

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

200

HEARN
M... ..

RECEIVED

District Health Officer No. 7,

District File Number 9-44-1094

Date Filed 10-4-44

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. 2478

working under my personal supervision.

Signed Fred Wickman

Licensed Embalmer No. 2478

P. O. Address Clinton 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.