

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36715

State File No. _____

Registration District No. 5782

Primary Registration District No. 4344

Registrar's No. 38

1. PLACE OF DEATH:
 (a) County. MONROE
 (b) City or town. PARIS
 (c) Name of hospital or institution:
LOCUST ST
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 15 yrs.
 In this community 15 yrs.
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County MONROE
 (c) City or town PARIS
 (If outside city or town limits, write "RURAL")
 (d) Street No. LOCUST ST.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. — years.

3. (a) PRINT FULL NAME MARY J. ALYERSON
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct. day 19
 year 1939 hour 7 PM minute 15 P. M.

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife JAS. M. ALYERSON
 6. (c) Age of husband or wife if alive ✓ years
 7. Birth date of deceased Nov. 11 1862
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 7,
 1939 to Oct 19, 1939
 that I last saw her alive on Oct 19, 1939
 and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 11 Days 8
 If less than one day hr. min.

Immediate cause of death Central apoplexy Duration 10 days
 Due to arteriosclerosis

9. Birthplace KINGSTREE SO. CAR.
 (City, town, or county) (State or foreign country)
 10. Usual occupation at home

Due to —
 Other conditions (include pregnancy within 3 months of death) —
 Major findings: Of operations —
 Of autopsy None

11. Industry or business —
 12. Name ROBT COOPER
 13. Birthplace SO CAR
 (City, town, or county) (State or foreign country)
 14. Maiden name FIRST NAME NA. FULTON
 15. Birthplace NK.
 (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's own signature R.C. Alyerson
 (b) Address 610 N. Locust St. Ottumwa
 17. (a) Autopsy (b) Date thereof 10-20-39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation New Hope
 18. (a) Signature of funeral director Speed & Blakey
 (b) Address Paris, Mo. 910
 19. (a) 10-20-39 (b) F.B. Barnett
 (Date received local registrar) (Registrar's signature)

23. Signature M.D. J.P. Marx (M. D. or other) —
 Address Paris, Mo. Date signed 10-20-39

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

Rev. 5-17-39
1 X 19311

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PHYSICIAN
 Underline the cause to which death should be charged statistically

RECEIVED

District Health Officer No. 10

District File Number 11-39-1916

Date Filed NOV 14 1939

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 W. B. Blakey

Licensed Embalmer No. 2616

P. O. Address Paris, 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, above space should be left blank.