

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

41038
Do not use this space.

1. PLACE OF DEATH

(a) County TEXAS Registration District No. 1643
 (b) Township OZARK Primary Registration District No. 1643 Registered No. _____
 (c) City YUKON (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 636 MARY FREDRICK St.
YUKON, MO. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A.J. FREDRICK
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9/9/1859
 7. AGE YEARS 80 MONTHS 2 DAYS 6 If LESS than 1 day,hra. ormin.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. HOUSEWIFE
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

FATHER 13. NAME WILLIAM WESTERMAN
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) BEDFORD TENN
 MOTHER 15. MAIDEN NAME UNKNOWN
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

17. INFORMANT (ADDRESS) DENVER FREDRICK ALIANCE, OHIO
 18. BURIAL, CREMATION, OR REMOVAL PLACE ALLEN DATE 11/16 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) RAYLORD V. ELLIOTT HOUSTON, MO.
 20. FILED Nov 20 1939 Alva G. M. White Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) NOV 15 1939
 22. I HEREBY CERTIFY, That I attended deceased from AUG 21 1939 to NOV 15 1939
 I last saw her alive on OCT 21 1939. Death is said to have occurred on the date stated above, at 3:20 A.M.
 The principal cause of death and related causes of importance were as follows:

CACHEXIA FROM CHRONIC BRONCHITIS OF UNKNOWN ETIOLOGY PROBABLY TUBERCULAR.
 Date of onset _____
 Other contributory causes of importance: SENILITY.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) J. M. O'Connell M.D.
 (Address) Houston Mo.

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.

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

RECEIVED
....., working under my personal supervision.

District Health Officer No. 5,

District File Number 1239458

Date Filed 12 8 39

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.