

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

44137

Do not use this space.

1. PLACE OF DEATH Texas
 (a) County Upton Registration District No. 1088
 (b) Township Upton Primary Registration District No. 6148 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 SYLVIA MARIE POSTLEWAIT
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 12 - 40
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
9 15
 OCCUPATION 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. _____
 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) Huggins Mo
 FATHER 13. NAME John Jefferson Postlewait
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Upton Texas
 MOTHER 15. MAIDEN NAME Lucy Frame Cleave
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arizona Missouri
 17. INFORMANT (ADDRESS) Huggins Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Union Chapel Cemetery DATE Oct 28 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) _____
 20. FILED Nov 10 1940 Mar Ke Hart Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) OCT. 27, 1940
 22. I HEREBY CERTIFY, That I attended deceased from OCT. 27, 1940 to OCT. 27, 1940
 I last saw her alive on OCT. 21, 1940 Death is said to have occurred on the date stated above, at 5:30 P.M.
 The principal cause of death and related causes of importance were as follows:
PACHY MENINGITIS Date of onset _____
DUETO NAIL PUNCTURE
OF SCALP _____
 Other contributory causes of importance: SEPTICEMIA FROM STREPTOCOCCUS IMPETIGO
 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 ACCIDENT Date of injury 10-21, 1940
 Where did injury occur? HOME OF CHILD
TEXAS CO. MO. (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. HOME
 Manner of injury FELL FROM BED ON NAIL
 Nature of injury PUNCTURED SCALP
 24. Was disease or injury in any way related to occupation of deceased? NO
 If so, specify _____ (Signed) J. M. Dullman M. D.
 (Address) HOUSTON, 1901

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.

RPL

Officer No. 5,

Number 12401165

Date Filed _____

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 _____

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44137
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1088

Primary Registration District No. 6149

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

1. PLACE OF DEATH:

(a) County Wheeler
(b) City or town Houston, 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 _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wheeler
(c) City or town Huggins, Mo
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U.S.A.? _____ years.

3. (a) PRINT FULL NAME

Sylvia Marie Postlewaite

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
9 15 _____ h _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name John Jefferson Postlewaite

13. Birthplace W. Va (City, town, or county) (State or foreign country)

14. Maiden name Lacey June Green

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

16. (a) Informant Huggins Mo
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Nov 10 - 1940 (b) Mrs R.E. Hart
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

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) (e) Means of injury _____

23. Signature L.M. Sullivan (M. D. or other) _____
Address Houston Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

