

Registration District No. 846

Primary Registration District No. 6110

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Stone
 (b) City or town Rural - Union Twp
 (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

3. (a) PRINT FULL NAME Frances Oswalt

3. (b) If veteran, name war _____ No. _____
 3. (c) Social Security No. _____

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

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

7. Birth date of deceased April - 4 - 1875
 (Month) (Day) (Year)

8. AGE: Years 66 Months 0 Days 0 If less than one day hr. _____ min. _____

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Crayton Campbell

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

14. Maiden name Jane Webster

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

16. (a) Informant Virginia Oswalt

(b) Address Billings - R-1

17. (a) Burial (b) Date thereof 4-5-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 2003 cem - Monett

18. (a) Signature of funeral director T.W. Maples

(b) Address Claver 220

19. (a) 4-9-41 (b) A.G. Osburn
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(e) State Mo (b) County Stone
 (c) City or town rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Billings Route #1.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4th day April
 year 1941 hour 1 minute 30 a. M.

21. I hereby certify that I attended the deceased from Nov. 29, 1940, to April 4, 1941;
 that I last saw her alive on March 25, 1941;
 and that death occurred on the date and hour stated above

Immediate cause of death Paralysis Right side Body

Due to _____
 Due to _____

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

Major findings: Of operations No operations
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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? No
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J.H. Wade (M. D. or other) _____
 Address Osark Mo Date signed 4-2-41

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

848

RECEIVED

District Health Officer No. 6

District File Number 441-635

Date Filed APR 13 1941

RES

SM. 2
-25-4-
XXXX I A

EMERSON, ANNEX

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 J. W. Maples

Licensed Embalmer No. 2985

P. O. Address Cleaver 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.

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

ROWENA MOORE

2B
-41
I X27852

Registration District No. 846

Primary Registration District No. 6110

Registrar's No. _____

1. PLACE OF DEATH

(a) County Stone

(b) City or town Union
(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

3. (a) PRINT FULL NAME Frances Oswald

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 m

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ year

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

8. AGE	Years	Months	Days	If less than one day
	<u>66</u>	<u>-</u>	<u>-</u>	hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH month apr day 7
year 1947 hour _____ minute _____ M.

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

Immediate cause of death Paralysis of
side Body
Central Nervous System.

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 J. T. Wade (M. D. or other) _____

Address Clark Mo Date signed 4-6-47

SUPPLEMENTARY

S-12279