

No. 2
4-12-40
5-17-39
X 23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28452**

FILED SEP 12 1941

Registration District No. **378**

Primary Registration District No. **4222**

Registrar's No. **48**

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

1. PLACE OF DEATH: **Howard**
 (a) County **Howard**
 (b) City or town **Fayette** *Missouri*
 (c) Name of hospital or institution: **503 Watts Ave.**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Life** *1* (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mrs. Betty F. Furr**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife **A. J. Furr** 6. (c) Age of husband or wife if alive **Deceased** years
 7. Birth date of deceased **Oct. 28, 1858**
 (Month) (Day) (Year)

8. AGE: Years **82** Months **9** Days **16** If less than one day hr. min.

9. Birthplace **Howard County, Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business _____

MOTHER FATHER { 12. Name **Otho Ashcraft**
 13. Birthplace **Howard Co. Mo.** (City, town, or county) (State or foreign country)

{ 14. Maiden name **Lucy Grady**
 15. Birthplace **Howard Co. Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. C. C. Furr**
 (b) Address **503 Watts Ave, Fayette, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Aug. 15/41** (Month) (Day) (Year)
 (c) Place: burial or cremation **City Cemetery**
L. J. Meister

18. (a) Signature of funeral director **L. J. Meister**
 (b) Address **Boonville, Mo.**

19. (a) **8-15-41** (Date received local registrar) (b) *[Signature]* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **045**
 (a) State **Missouri** (b) County **Howard**
 (c) City or town **Fayette,** (If outside city or town limits, write "RURAL")
 (d) Street No. **503 Watts Ave.** (If rural, give location)
 (e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Aug.** day **13th.** year **1941** hour **4.30** minute **P.** M.

21. I hereby certify that I attended the deceased from **June 29**, 1941, to **Aug. 12**, 1941; that I last saw her alive on **Aug. 12**, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: **Suprastate pneumonia - Her myocarditis -**

Due to _____
 Due to _____

Other conditions: **Fracture of hip!** (Include pregnancy within 3 months of death) **6 weeks**

Major findings: **Serum**
 Of 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 **045**
 (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) (c) Means of injury **H**

Signature **M. P. Beal M.D.** (M. D. or other)
 Address **See Hospital Fayette, Mo.** Date signed **8-15-41**

Russ W. At
501 D. W. St

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-11-41

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 C. R. Felton
Licensed Embalmer No. 1399
P. O. Address W. Lee St

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28452

Registration District No. 378

Primary Registration District No. 4222

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howard

(b) City or town Jayette
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs Betty L. Furr

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 W

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 82 Months 9 Days _____
(If less than one day, in 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 Aug Day _____
Year 1941 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____
that I last saw him/her alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

hypostatic pneumonia
MI myocarditis

Due to _____

Due to _____

Other conditions fracture of hip
Senility
(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) accident

(b) Date of occurrence June 30, 1941

(c) Where did injury occur Home - Jayette, MO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? no (Specify type of place)
to ball field (c) Means of injury fall getting

23. Signature W. P. Beach, MD (M. D. or other) _____
Address Lee Hospital, Jayette, MO Date signed _____

SUPPLEMENTARY

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

Jayette MO

5-28452