

FILLED DEC 5 7 1941

State File No. _____

Registration District No. 7997

Primary Registration District No. 6043

Registrar's No. 3031

1. PLACE OF DEATH

(a) County Saline
(b) City or town Slater Rural 7072
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Clear Lake
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline
(c) City or town Slater Rural 097
(If outside city or town limits, write "RURAL")
(d) Street No. R F D # 2
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2 year 1941 hour 2 minute 30 P. M.
21. I hereby certify that I attended the deceased from one visit Oct 2, 1941, to Oct 2, 1941; that I last saw her alive on Oct 2, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: "Heart's heart!"
mitral valve
Due to Pneumonia 6 months ago

Due to _____
Other conditions none
(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 Q
23. Signature R.H. Mercedes (M. D. or other) DO
Address Slater, Mo Date signed Oct 4-41

3. (a) PRINT FULL NAME Helen Louise Fiser

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓
4. Sex Female 5. Color or race White 6. (a) Single, ~~married~~ divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: December 25 / 1940
(Month) (Day) (Year)

8. AGE: Years 0 Months 9 Days 4 If less than one day hr. _____ min. _____

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

10. Usual occupation Baby

11. Industry or business _____

12. Name Marvin Fiser

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

14. Maiden name Fischer, Elizabeth

15. Birthplace Slater Mo R F D # 2 (City, town, or county) (State or foreign country)

16. (a) Informant Marvin Fiser

(b) Address Slater Mo # 2

17. (a) Slater (b) Date thereof 10-4-41 (Burial, cremation, or removal) (Month), (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Elmer

(b) Address Slater Mo

19. (a) Oct. 8, 1941 (b) Ella Alexander (Date received local registrar) (Registrar's signature)

(c) _____

(d) _____

(e) _____

(f) _____

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

X23153

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-4-41.....

11100

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.

Signed.....

R. E. Jones

Licensed Embalmer No.

P. O. Address.....

Slater 3/4

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 39616

Registration District No. 799

Primary Registration District No. 6043

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Staley
(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)

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 _____

3. (a) PRINT FULL NAME Helen L. Taylor

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 12 Year 1944 hour _____ minute _____ M.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Dec 28 1914
(Month) (Day) (Year)

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 _____

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

Due to Bronchial pneumonia

Due to _____

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

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

10. Usual occupation _____

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

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 _____

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 H. H. Nevels (M. D. or other) MD

Address Staley Mo Date signed 7/12/44

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

