

1. PLACE OF DEATH:
 (a) County Dallas
 (b) City or town Buffalo 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 _____
(Specify whether years, months or days)
 In this community 4 months

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Dallas
 (c) City or town Buffalo Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ESSIE MAY FOX
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan - day 12
 year 1942 hour 10 minute PM

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife J.C. FOX 6. (c) Age of husband or wife if alive 65 years
 7. Birth date of deceased Sept-28-1892
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from OK
Jan 12, 1942,
 that I last saw her alive on Jan 12, 1942
 and that death occurred on the date and hour stated above.

8. AGE: Years 49 Months 3 Days 15 If less than one day _____ hr. _____ min.

Immediate cause of death Coronary Occlusion
 Due to Hypertension
 Due to Obesity Hypertension
 Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Oskaloosa Iowa
(City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

Major findings: Of operations gwa
 Of autopsy _____

MOTHER FATHER
 11. Industry or business _____
 12. Name Johnathan Nelson
 13. Birthplace Eddyville Iowa
(City, town, or county) (State or foreign country)
 14. Maiden name Margaret J. Kelly
 15. Birthplace Bellare Ohio
(City, town, or county) (State or foreign country)

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

16. (a) Informant J.C. FOX
 (b) Address Buffalo Mo
 17. (a) Harland (b) Date thereof Jan 14 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Old Zions
 18. (a) Signature of funeral director B. Jones
 (b) Address Buffalo Mo
 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 G. Blummer (M. D. or other) MD
 Address Buffalo Mo Date signed 1-13-42

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

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 *Lloyd Montgomery*
Licensed Embalmer No. *3592*
P. O. Address *Buffalo 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 241

Primary Registration District No. 4147

Registrar's No.

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Buffalo
(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

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 Essie M. Froy

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 _____ years

7. Birth date of deceased Sept 28
(Month) (Day) (Year)

8. AGE: Years 49 Months _____ Days _____
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) 1/13/42 (b) John D. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day _____
Year 1942 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 _____

Due to _____

Due to _____

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

Major findings:
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 _____

(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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

