

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 171

Registration District No. 384

Primary Registration District No. 4227

1. PLACE OF DEATH:

(a) County Howe

(b) City or town West Plains town
(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 5 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo County Howe

(c) City or town West Plains
(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 Jda Beel Clow

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 23 year 1942 hour 4 minutes 35 P. M.

4. Sex 7-1 Color or race W

6. (a) Name of husband or wife Jda Clow

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased 4-15-1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10-5-1940 to 6-23-1942 that I last saw him alive on 6-20-1942 and that death occurred on the date and hour stated above.

8. AGE: Years 69 Months 2 Days 8 If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral thrombosis
Fracture of left femur-neck 6-2-42

Due to Hypertension, general arteriosclerosis

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

10. Usual occupation Housewife

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

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name Wm Lavatzer

13. Birthplace Germany (City, town, or county) (State or foreign country) 1

14. Maiden name _____

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Fred Clow

(b) Address Avonia La

17. (a) (b) Date thereof 6-24-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director Wm Hart

(b) Address West Plains, Mo

19. (a) 7-4-42 (Date received local registrar) Paul K... .. (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 046

(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 _____

Signature E. C. Bohrer (M. D. or other) MD

Address West Plains, Mo Date signed 7-1-42

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

RECEIVED

District Health Officer No. 5,

District File Number

742646

Date Filed

8-19-42

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

D. J. Roberts

Licensed Embalmer No.

3430X

P. O. Address

West Hill, N.Y.

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. 27313
Registrar's No. 71

Registration District No. 384

Primary Registration District No. 4227

1. PLACE OF DEATH:

(a) County Hawell
(b) City or town West Plains
(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

Ida Beal Stone

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. April (Month) 15 (Day) 1869 (Year)

8. AGE: Years 69 Months 2 Days 1 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) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

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

19. (a) (Date received local registrar)..... (b) (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 June Day 8 year 1942 hour..... minute..... M.

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

Immediate cause of death cerebral thrombosis
fracture of left femur
Due to neck
Due to hypertension general arteriosclerosis

Other conditions (Include pregnancy within 3 months of death) 186a

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) accidental fall
(b) Date of occurrence June 8 1942
(c) Where did injury occur? West Plains Hawell Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? in home

While at work? yes (Specify type of place) (e) Means of injury fall from chair

23. Signature E. P. Bohrer (M. D. or other) MD
Address West Plains Mo Date signed.....

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

SUPPLEMENTARY

