

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35043**

FILED NOV. 11 1942

Registration District No. **354**

Primary Registration District No. **6200**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Fowler, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1. Missouri Valley
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas **107**

(c) City or town Fowler, Mo. **9**
(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 0

3. (a) PRINT FULL NAME HENRY C. Amos

3. (b) If veteran, name war No

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12
year 1942 hour 2:00 minute 19 A. M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Goldie Memory Amos

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Dec. 28 1889
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10-11-42 to 10-12-42
that I last saw him alive on 10-11-42
and that death occurred on the date and hour stated above.

8. AGE: Years 53 Months 9 Days 14
If less than one day _____ hr. _____ min.

Immediate cause of death Coronary Thrombosis **3 days**
Duration _____

9. Birthplace Texas County Missouri
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

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

10. Usual occupation FARMER

11. Industry or business _____

Major findings:
Of operations _____

Of autopsy _____

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

MOTHER FATHER { 12. Name John Whitfield Amos

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

14. Maiden name Della Frances Neighbors

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

16. (a) Informant Wife

(b) Address Fowler, Mo. (R.F. Mtn. Grove)

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? _____

17. (a) BURIAL (b) Date thereof Oct. 13, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mountain Grove, Mo.

While at work? _____ (Specify type of place)

(e) Means of injury 2. G. Frame

18. (a) Signature of funeral director Russell Barber

(b) Address Mtn. Grove, Mo.

23. Signature H. G. Frame (M. D. or other)
Address Mountain Grove, Mo. Date signed 10/14/42

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

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

RECEIVED
District Health Officer No. 6,
District File Number _____
Date Filed NOV 6 1942

RECEIVED
District Health Officer No: 5
District File Number 114297A
Date Filed 11-10-42

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 35043

Registration District No. 354

Primary Registration District No. 1200

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town London
(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 Henry C. Amos
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 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 Dec 18 (Month) 18 (Day) 19 (Year)

8. AGE: Years 52 Months 9 Days 11 (If less than one day _____ min. _____)

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

10. Usual occupation _____

11. Industry of 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) Dec-3-1942 (Date received local registrar) (b) Mrs. Lon Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October Day 12 year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Due to _____
Due to _____

Other conditions _____ (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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

35043