No. 2
M—5-42
v. 5-17-39
I X32873

22
0
0

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

36884

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED DEC 12 1942

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. ~~122~~ 69 Primary Registration District No. 5453-5 271 Registrar's No.

1. PLACE OF DEATH:

(a) County Christian

(b) City or town Rural- Logan Dup
(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 17 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Christian 22 0

(c) City or town rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. Brookline, R#1
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Myrtle Agnes Posten.

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Avery Posten

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased October, 29, 1900
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
42		17	hr. min.

9. Birthplace Monett- (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name U.S. Kimes
13. Birthplace Arkansas (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name Mary E. Arnold
15. Birthplace Texas (City, town, or county) / (State or foreign country)

16. (a) Informant Mr. Avery Posten
(b) Address Brookline, Mo R#1.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 42 (Month) (Day) (Year)
(c) Place: burial or cremation Bloodland cemetry near Waynesville

18. (a) Signature of funeral director T. L. Maples
(b) Address Clever, Mo.

19. (a) Nov. 17-'42 (Date received local registrar) (b) Florence Britain (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16
year 1942 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from February 24, 1942 to Nov 16 - 1942
that I last saw her alive on Nov 16 - 1942, 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis	10 Months
Due to	
Due to	
Other conditions (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)
(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 R C Mitchell (M. D. or other) DO.
Address Republic Mo Date signed 11/17/42

1249

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED DEC 16 1942
Greene County Health Office
County File Number 42-12-97
Date Filed 12/16/42

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 J.W. Maples

Licensed Embalmer No. 2985

P. O. Address Clever, Mo.

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.

B
-41
288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 368884

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:
(a) County: Christian County
(b) City or town: Brookline Route 1.
(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 .....

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: Myrtle Agnes Poston
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: Oct (Month) 29 (Day) 1899 (Year)
8. AGE: Years 42 Months — Days ..... If less than one day ..... hr. ..... min.
9. Birthplace: (City, town, or county) ..... (State or foreign country) Mo
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 6 year 1942 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h... alive on ..... 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 .....

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)
(b) 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 .....

SUPPLEMENTARY 6

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36884

Registration District No. 122 Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County: Christian

(b) City or town: Rural (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 .....

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: Myrtle Agnes Pasten

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: Oct (Month) 29 (Day) 1900 (Year)

8. AGE: Years 42 Months ..... Days ..... If less than one day: ..... hr. ..... min.

9. Birthplace: ..... (City, town, or county) Mo (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 16 year 1942 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... to ....., 19.....; that I last saw him alive on ....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death: Tuberculosis Lungs

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

While at work? ..... (c) Means of injury .....

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

Address ..... Date signed .....

SUPPLEMENTARY

13 d