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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11768

FILED APR 14 1943
Registration District No. 360

Primary Registration District No. 3076

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Nevada, Mo. 710 S. Spring St.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 33 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Martha Bell Waite

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John Waite 6. (c) Age of husband or wife if alive 83 years
7. Birth date of deceased July 27, 1856
(Month) (Day) (Year)

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

9. Birthplace New Albany, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name J. W. Weaver
13. Birthplace New Albany, Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Ann Weaver
15. Birthplace North Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant John Waite
(b) Address 710 S. Spring St. Nevada, Mo
17. (a) Burial (b) Date thereof Mar 30 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Quinton Cemetery
18. (a) Signature of funeral director Ways Funeral Home
(b) Address Nevada, Mo
19. (a) 3-29-43 (b) Hazel B. Bewick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon
(c) City or town Nevada
(If outside city or town limits, write "RURAL")
(d) Street No. 710 S. Spring St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 28th
year 1943 hour 12:35 minute P. M.

21. I hereby certify that I attended the deceased from 1941 to Mar 26, 1943
that I last saw her alive on March 19, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Due to Frequent attacks of asthma
Due to

Other conditions Advanced age.
(Include pregnancy within 3 months of death)

Major findings: 92e!
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) (c) Means of injury
23. Signature J. H. Love, M.D. (M. D. or other)
Address Nevada, Mo Date signed 3-28-43

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

RECEIVED

District Health Officer No. 7.

District File Number

3-43-31

Date Filed

4-6-42

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

Mack A. Braswell

Licensed Embalmer No. 2529.

P. O. Address *Nevada* *no*

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. 11768
Registrar's No. 26

Registration District No. 360

Primary Registration District No. 3076

1. PLACE OF DEATH:

(a) County Wernan
(b) City or town Nevada, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
710 S. Spring St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (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 Martha Bell White

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 July 27 (Month) (Day) (Year)

8. AGE: Years 86 Months 8 Days 13 (If less than one day, min.)

9. Birthplace New Albany Ind. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or 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 Hayes Funeral Home

(b) Address Nevada, Mo.

19. (a) 3-29-48 (b) Hazel B. Beusch (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day _____ Year 1943 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 _____

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

MOTHER FATHER

SUPPLEMENTARY

S-11768