

S. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 4 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14452**

Registration District No. **11** Primary Registration District No. **5007** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Howell**
(b) City or town **Peace Valley Mo**
(c) Name of hospital or institution: **Sumner Hosp**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **36 hrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Howell**
(c) City or town **Peace Valley Mo**
(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 **Jarah B. Fike**
3. (b) If veteran, name war 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **1** day **21**
year **1943** hour **21** minute **00** A.M.
21. I hereby certify that I attended the deceased from **3-18-1941** to **1-2-1943**
that I last saw him alive on **12-16-1942**
and that death occurred on the date and hour stated above.

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **P. R. Fike** 6. (c) Age of husband or wife if alive **79** years
7. Birth date of deceased **8-29-1866**
(Month) (Day) (Year)

Immediate cause of death
Chronic Arteriosclerotic Myocarditis
Coronary Sclerosis
Due to _____
Due to **gpd**
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years **76** Months **4** Days **3** If less than one day hr. min.
9. Birthplace **Wittlinger Mo**
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

10. Usual occupation **Housewife**
11. Industry or business _____
12. Name **Christian Beachy**
13. Birthplace **md.**
(City, town, or county) (State or foreign country)
14. Maiden name **Marion Beachy**
15. Birthplace **Accident md.**
(City, town, or county) (State or foreign country)
16. (a) Informant **P. R. Fike**
(b) Address **Peace Valley Mo**
17. (a) _____ (b) Date thereof **1-4-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **near Hope**
18. (a) Signature of funeral director **Robert Bohrer**
(b) Address **West Plains Mo**
19. (a) **4-6-43** (b) _____
(Data 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 **E. C. Bohrer** (M. D. or other) **MD**
Address **West Plains Mo** Date signed **4-2-43**

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

16
00

RECEIVED

District: No. 5

District File No. 343258

Date Filed ~~DECEMBER 12 1943~~

Special Agent, Bureau of the Census
District Health Officer No. 5,
SALEM, MISSOURI

RECEIVED

RECEIVED

District Health Officer No. 5,

District File Number 343258

Date Filed 5-3-43

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 L. L. Roberts

Licensed Embalmer No. 3432

P. O. Address West Plains, 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

State File No. 1448-2
Registrar's No. _____

Registration District No. 142

Primary Registration District No. 6-5-5-7

1. PLACE OF DEATH:

(a) County: Franklin

(b) City or town: Peace Valley
(If outside city or town limits, write "RURAL" and name 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: _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Sarah B Fike

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: W

6. (b) Name of husband or wife: P.H. 6. (c) Age of husband or wife if alive: 79 years

7. Birth date of deceased: Aug 29 - 1943
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 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) (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) May 29 1948 (b) Ruth Hunt
(Date received local registrar) (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 January year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I saw her _____ live 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: _____

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 UNFADEING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-14452