

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

**FILED JUN 11 1943**

Registration District No. 308 Primary Registration District No. 6239

1. PLACE OF DEATH:  
 (a) County Washington  
 (b) City or town Bismarck, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Robertson Camp  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution three years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Washington  
 (c) City or town Brookdale, Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Belleview, T.S.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME Doct Maurice  
 3. (b) If veteran, name war 0  
 3. (c) Social Security No. 0

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month MAY day 14  
 year 1943 hour 12 minute A M.  
 21. I hereby certify that I attended the deceased from 3-1  
1940 to 3-14, 1943  
 that I last saw him alive on 3-11, 1943  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife Nancy Moolers  
 6. (c) Age of husband or wife if alive 14 years (Date) 1855 (Year)

Immediate cause of death nephritis ✓  
 Duration 0

8. AGE: Years 88 Months 0 Days 0  
 If less than one day 0 hr. 0 min.

Due to 0  
 Due to 0  
 Other conditions 0  
(Include pregnancy within 3 months of death)

9. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
 10. Usual occupation nothing retired  
 11. Industry or business 0  
 12. Name Michel Maurice  
 13. Birthplace Kent.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Barnes  
 15. Birthplace Kent.  
(City, town, or county) (State or foreign country)

PHYSICIAN  
 Major findings: 0  
 Of operations 0  
 Of autopsy 0  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Sherman Smith  
 (b) Address Bismarck, Mo  
 17. (a) Burial (b) Date thereof 3-14-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Hourds Mill, Mo  
 18. (a) Signature of funeral director COZAN, Funeral Home  
 (b) Address Lebanon, Mo  
 19. (a) 3-14-43 (b) Ella White  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) 0  
 (b) Date of occurrence 0  
 (c) Where did injury occur? 0  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? 0 (Specify type of place)  
 (e) Means of injury 0  
 23. Signature J.P. Yeung (M. D. or other)  
 Address Brookdale, Mo Date signed 3-15-43

RECEIVED

District Health Officer No. 4  
District File Number 643-2307  
Date Filed 6-7-43

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.....

*me*  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*McCozen*  
.....  
Licensed Embalmer No. 4084

P. O. Address. Farmington, CT

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 365

Primary Registration District No. 6239

Registrar's No. 13

1. PLACE OF DEATH: Washington  
 (a) County Washington  
 (b) City or town Belgrade  
 (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 Doek Maurice  
 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 w  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: March 14 1910  
 (Month) (Day) (Year)

8. AGE: Years 88 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (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) \_\_\_\_\_ (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 March 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 repeated Duration \_\_\_\_\_  
Chronic Don't know

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 131

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

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

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER, FATHER

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

S-19333