

JUN 29 1943

85 42

Registration District No. 1001/000

State File No. \_\_\_\_\_

Registrar's No. 686

1. PLACE OF DEATH:

(a) County. BUCHANAN  
 (b) City or town. ST. JOSEPH!  
 (c) Name of hospital or institution: State Hospital No. 2  
 (d) Length of stay: In hospital or institution. 8 days  
 In this community. 8 days

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Clintony  
 (c) City or town. Osborne  
 (d) Street No. 1  
 (e) Citizen of foreign country? No.  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MYATLE TALBOTT

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. Single

6. (b) Name of husband or wife. \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. unknown 1876  
 (Month) (Day) (Year)

8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace. \_\_\_\_\_ (City, town, or county) Missouri (State or foreign country)

10. Usual occupation. \_\_\_\_\_

11. Industry or business. Lived on Farm

MOTHER, FATHER { 12. Name. unknown  
 13. Birthplace. unknown 9 (City, town, or county) (State or foreign country)  
 14. Maiden name. unknown  
 15. Birthplace. unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant. Deputy Sheriff J. T. Holman

(b) Address. Cuba, Missouri

17. (a) Removal (b) Date thereof June 24-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Osborne, Mo.

18. (a) Signature of funeral director. J. G. Moore

(b) Address. Stewartville

19. (a) 6-24-43 (b) Rose Higgins  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22  
 year 1943 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from 6-16, 1943 to June 22, 1943

that I last saw her alive on June 22, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death. uracemia  Duration 1 week

Due to hypertension

Due to Rheumatism

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? \_\_\_\_\_

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

23. Signature. J. H. Morrison (M. D. or other) \_\_\_\_\_

Address State Hospital No. 2 Date signed 1-25-43

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

123 St. Joseph, Mo

**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 F. G. Lyon

Licensed Embalmer No. 952

P. O. Address Stewartville Md

**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. July  
Registrar's No. 686

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(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 Myrtle Falbalt  
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 S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 67 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 \_\_\_\_\_ year 1943 minute \_\_\_\_\_ M. \_\_\_\_\_  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ 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 Uremia  
chronic Nephritis

Due to Hypertension  
Due to Rheumatism  
Other conditions (Include pregnancy within 3 months of death) 131  
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 J. H. Marroway (M. D. certifier)  
Address State Capital Bldg. Date signed 7/2/43

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

SUPPLEMENTARY 2

709107