

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27586**

FILED SEP 13 1943

Primary Registration District No. **5031**

Registrar's No. **27**

1. PLACE OF DEATH:

(a) County **AUDRAIN**
 (b) City or town **RURAL CIVILRETRP**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2 miles west of Vandavia
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community **3 yrs.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **AUDRAIN**
 (c) City or town **RURAL CIVILRETRP**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **ARTHUR WESLEY SOUTHWICK**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **EMMA LAYLIN SOUTHWICK** 6. (c) Age of husband or wife if alive **57** years
 7. Birth date of deceased **DEC 27 1866**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 8 4 hr. min.

9. Birthplace **EL PASO TEXAS** **ILLINOIS**
 (City, town, or county) (State or foreign country)

10. Usual occupation **FARMING**

11. Industry or business _____

MOTHER FATHER { 12. Name **JOSEPH SOUTHWICK**
 13. Birthplace **EL PASO TEXAS** **ILLINOIS**
 (City, town, or county) (State or foreign country)
 14. Maiden name **ELIZABETH JAY SOUTHWICK**
 15. Birthplace **EL PASO TEXAS** **ILLINOIS**
 (City, town, or county) (State or foreign country)

16. (a) Informant **MRS EMMA SOUTHWICK**

(b) Address **VANDAVIA MO.**

17. (a) **BURIAL** (b) Date thereof **SEPT 3 1943**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **VANDAVIA CEMETARY**

18. (a) Signature of funeral director **Wm E Smith**

(b) Address **Vandavia, Mo.**

19. (a) **Sept 3 1943** (b) **Thelma Ferguson**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **31st**
 year **1943** hour **09** minute **15** P.M.

21. I hereby certify that I attended the deceased from **August 15**, 1943 to **August 31**, 1943
 that I last saw him alive on **August 31**, 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death **Mycocarditis (Acute)** **2 days**

Due to **Endocarditis (Chronic)** **6 wks**

Due to **Acute diffuse interstitial myocarditis** **8 wks**

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 **R. L. Marshall** (M.D. or other) **D.O.**
 Address **Vandavia** Date signed **Sept 2**

WRITE PLAINLY—USE UNFADING BLACK INK—MAY BE A PERMANENT RECORD

1073

RECEIVED

District Health Officer, No. 22

District File No. 9-43-1511

SEP 10 1943

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 *Chester A Roof*

Licensed Embalmer No. *3048*

P. O. Address *Rolling Green*

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. Sept.
Registrar's No. _____

Registration District No. 6 Primary Registration District No. 5031

1. PLACE OF DEATH:
(a) County Andrew
(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)
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 Arthur Wesley Southwick
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 31 year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex _____ 5. Color or race _____
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Duration _____

7. Birth date of deceased: Dec. 27 1866
(Month) (Day) (Year)
8. AGE: Years 76 Months 8 Days _____ If less than one day _____ min.

Due to acute diffuse interstitial nephritis
Due to chronic diffuse interstitial nephritis 8 mo.

9. Birthplace _____ (City, town, or county) (State or foreign country)

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

10. Usual occupation _____

Major findings: 131a
Of operations _____

11. Industry or business _____

Of autopsy _____
Underline the cause to which death should be charged statistically.

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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) _____

(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 D. P. Marshall (M.D. or other) DD

Address Sandalia Winona Date signed Sept 1

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKES PERMANENT RECORD

27586