

No. 2
9-4-41
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31756

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 11 1943

Registration District No. 41

Primary Registration District No. 5513025

Registrar's No. 98

1. PLACE OF DEATH:

(a) County Haskell

(b) City or town West Plains Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
West Plains
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 years (Specify whether years, months or days)

In this community 2 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Haskell

(c) City or town West Plains 046
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country none

3. (a) PRINT FULL NAME Margate L. Trail

3. (b) If veteran, name war -

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Sept day 11 at 11:30 AM
year 1943 hour 2 minute 30

4. Sex F. 1

5. Color of race White

6. (a) Name of husband or wife -

6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased Jan 19 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-9-1942 to 9-11-1943

that I last saw her alive on 9-7-43, 1943
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 8 Days 23
If less than one day hr. min.

Immediate cause of death Cerebral Thrombosis
Left Hemiplegia
Due to Arteriosclerosis

Due to

Other conditions (include pregnancy within 3 months of death) 83 f

MOTHER FATHER

11. Industry or business Housekeeper

12. Name Waldon

13. Birthplace Link Grove
(City, town, or county) (State or foreign country)

14. Maiden name Link Grove

15. Birthplace Link Grove
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Ruffel Chesell

(b) Address Baral Mo

17. (a) Burial (b) Date thereof Sept 12 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Trail Cemetery

18. (a) Signature of funeral director me Blue Johnson

(b) Address Baral Mo

19. (a) 9-11-43 (b) [Signature]
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

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?.....

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

23. Signature E. C. Bohrer (M. D. or other) mo

Address West Plains Mo Date signed 9-11-43

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

RECEIVED

District Health Officer No 5,

District File Number 1043609

Date Filed 10-8-42

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

Lawrence L. Hall

Licensed Embalmer No.

2784

P. O. Address

Gainesville

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.

Registration District No. 144

Primary Registration District No. 3025

1. PLACE OF DEATH:

(a) County Hawell
(b) City or town West Plains
(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

3. (a) PRINT FULL NAME Margaret L. Trail

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

4. Sex W 5. Color or race W 6. (a) Single, widowed, married, divorced SW

6. (b) Name of husband or wife T. Trail 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 19 1908
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days _____ If less than one day, _____ min.

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

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Trail
(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 Sept day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I examined 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 _____

Duration _____

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 UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

31756