

S. No. 2  
M-2-43  
5-17-43  
PI X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

35812

FILED NOV 6 1943

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 339

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Mo. State Hospital No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mos. 26 das.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carter

(c) City or town Ellsinore  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARGARET E. (BOXX) BOX

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race W.

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Mathew Box

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

7. Birth date of deceased November 5, 1870  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 10, year 1943 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from August 14, 1943 19 to October 10, 1943 19 that I last saw her alive on October 10, 1943 19 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>11</u>	<u>5</u>	hr. _____ min.

Immediate cause of death Cerebral arteriosclerosis

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Cave Creek, Ripley Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name Benjamin Seats

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

14. Maiden name Sara Kusinger

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

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 \_\_\_\_\_

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Seats Cem., Ellsinore, Mo.

18. (a) Signature of funeral director Frank Funeral Home

(b) Address Poplar Bluff, Mo.

19. (a) Oct 22, 1943 (Date received local registrar)

(b) Byrdia Bukhmaster (Registrar's signature)

23. Signature M. J. Ferguson (M. D. or other) M.D.

Address 408 N. First Date signed 10/11

1196 (Licensed Embalmer's Statement on Reverse Side) Farmington, Mo.

RECEIVED

District Health Officer No. 4  
District File Number 1143-2878  
Date Filed 11-5-43

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**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 *Edward W. Green*  
Licensed Embalmer No. 2964  
P. O. Address *Capital Bluff 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.**