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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 19 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38658

Registration District No. 18

Primary Registration District No. 3040

State File No. _____

Registrar's No. 128

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 419 west wire 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 4 weeks (Specify whether)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County Deaf Smith
(c) City or town Hersford (If outside city or town limits, write "RURAL") 11
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 2

3. (a) PRINT FULL NAME OZELLA RUDD

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, 2 divorced, widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased April 30 1972
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 6 11 hr. _____ min.

9. Birthplace Livingston Co mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name John J. Phillips
13. Birthplace Livingston Co mo 0
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Myrneria Coberly
15. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

16. (a) Informant B. B. Phillips
(b) Address Chillicothe, Mo.
17. (a) Burial (b) Date thereof Nov 14 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wallace cemetery
18. (a) Signature of funeral director E. P. Robertson
(b) Address Farede, Mo.
19. (a) Nov 25 (b) h. v. L. C. Curry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11
year 1943 hour 5 minute 55 P.M.

21. I hereby certify that I attended the deceased from 25
43 to Nov-11-43
that I last saw her alive on Nov-10-43
and that death occurred on the date and hour stated above,
Immediate cause of death Pneumonia Duration 5 days

Due to Unknown

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 B. B. Phillips (M. D. or other) _____
Address Chillicothe, Mo. Date signed _____

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

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.....

John M. Robertson, Registered Apprentice No. *355*
working under my personal supervision.

Signed *E. J. Robertson*

Licensed Embalmer No. *2418*

P. O. Address *Fargo, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Chillicothe
(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 4 mo
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Ozella Rudd

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

4. Sex 7 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 April 20 1907
(Month) (Day) (Year)

8. AGE: Years 71 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 _____
(Burial, cremation, or removal) (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 Nov. Day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Bronchial

Due to unk.

Due to _____

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. M. Weaver (M. D. or other)

Address Chillicothe Mo Date signed 7/3/44

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

MOTHER FATHER

SUPPLEMENTARY

Duration 5 da.

PHYSICIAN

Underline the cause to which death should be charged statistically.

38658