

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

Registrar's No. 47

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS  
FILED DEC 8 1943  
FILED DEC 3 1943  
Registration District No. 3475

Primary Registration District No. 6151

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Parma, Rt 1 (ex)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
In this community 14 Months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard  
(c) City or town Rural 103  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7 mi N-W of Parma 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ESTERLINE-GARY

3. (b) If veteran, name war None 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race 3 Negro 6. (a) Single, widowed, married, divorced, Single  
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Month) (Day) (Year)

7. Birth date of deceased Aug 26 - 42  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 3 8 hr. min.

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

10. Usual occupation None

11. Industry or business None

MOTHER FATHER { 12. Name M. C. Gary  
13. Birthplace Holmes Co. Tenn. (City, town, or county) (State or foreign country) 1  
14. Maiden name May Henry  
15. Birthplace Louisiana (City, town, or county) (State or foreign country) State 1

16. (a) Informant M. C. Gary  
(b) Address Parma, Mo. Rt 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-43 (Month) (Day) (Year)

(c) Place: burial or cremation Catron Mo.

18. (a) Signature of funeral director Walter J. Seaver  
(b) Address Parma, Mo.

19. (a) 11-24-43 (Date received local registrar) (b) Carrie Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 3rd year 1943 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from 10-21-43 to 11-3-43, 19\_\_\_\_; that I last saw her alive on 11-1-43, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia  
Due to Tuberculosis  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 9

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 J. H. Gilbert (M. D. or other) 2-60  
Address Parma, Mo. Date signed 11/8/43

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

No. 2  
-2-43  
5-17-39  
I X35697

RECEIVED

District Health Office No. 2,

District File Number 1243-1510

Date Filed 12-6-43

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**