

S. No. 2  
M-2-43  
17-39  
X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41982  
Registrar's No. 98

FILED JAN 11 1943  
Registration District No. 15

Primary Registration District No. 5291

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Liberty Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
I.O.O.F. Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Aug 25, 1943  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Fannie Black

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife David Black

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

7. Birth date of deceased Mar. 15 1858  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>85</u>	<u>9</u>	<u>8</u>	hr. _____ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant I.O.O.F. Home Records

(b) Address Liberty Mo.

17. (a) Removal (b) Date thereof 12-22-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Mo.

18. (a) Signature of funeral director Clark Mortuary

(b) Address St Joseph, Mo. 5025 King Hill Ave

19. (a) 12-22-43 (b) Helen Early  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Michigan (b) County 999

(c) City or town Detroit 20  
(If outside city or town limits, write "RURAL")

(d) Street No. 0  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 21

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 21  
year 1943 hour 11 minute 35 P.M.

21. I hereby certify that I attended the deceased from Oct 30, 1943, to Dec 21, 1943  
that I last saw him alive on Dec 21, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Shock from fractured left hip

Due to General Atherosclerosis 10 yrs

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) 024

(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) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

23. Signature Burton Mather M.D.

(M. D. or other) \_\_\_\_\_

Address Liberty Mo Date signed 12-22-43

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

9db

RECEIVED

District Health Officer No. 8;

District File Number \_\_\_\_\_

Date Filed 12-10-44

*W. Lawrence*

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 *Emmalark*

Licensed Embalmer No. 4238

P. O. Address *St Joseph 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. Jan.  
 Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:  
 (a) County Clay  
 (b) City or town Marion  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 2007 Home  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)  
 3. (a) PRINT FULL NAME Jannie Black  
 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 Mar. 15 1857  
(Month) (Day) (Year)

8. AGE: Years 85 Months 9 Days \_\_\_\_\_  
(If less than one day, hr. min.)

9. Birthplace Prussia  
(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 Dec year 1943 day \_\_\_\_\_ 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 shock from fractured left hip general arterio sclerosis Duration 6 hrs 10 min

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

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) accident

(b) Date of occurrence Nov 8, 1943

(c) Where did injury occur? Liberty Clay Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? in home P.O.P. Hospital

While at work? no (Specify type of place)

(e) Means of injury Fall

23. Signature Burton Mallery (M. D. or other) M.D.

Address Liberty Mo Date signed 11-14

SUPPLEMENTAL

MENTAL

186 a  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

S-41982