

No. 2  
-2-43  
17-39  
X35697

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43990**  
Registrar's No. **51**

FILED JAN 7 1944  
Registration District No. **371**

Primary Registration District No. **6152a**

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Dexter, R. 2, ~~Stoddard~~  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 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.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED: **10.3**

(a) State Missouri (b) County Stoddard

(c) City or town Dexter, Mo. R. 2.  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country?..... (Yes or No)  
**0**  
If yes, name country.....

3. (a) PRINT FULL NAME Mary Ellen Fonville,

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.....

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

7. Birth date of deceased Nov. 3, 1862  
(Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 12  
If less than one day  
hr. .... min.

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

10. Usual occupation House keeper

11. Industry or business.....

MOTHER FATHER

12. Name Abe Goodman

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

14. Maiden name Polly Ann Ward

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

16. (a) Informant Tom Fonville,

(b) Address 1001 Hannible Dexter, Mo.

17. (a) Burial ~~xxxxxx~~ (b) Date thereof Dec. 17, 43  
(Burial, cremation, & removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dexter, Mo.

18. (a) Signature of funeral director Watkins Funeral Ser

(b) Address Dexter, Mo.

19. (a) 12-24-43 (b) Mona Smith  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16  
year 1943 hour 3 minute P M.

21. I hereby certify that I attended the deceased from Dec. 10 - 1943 to Dec. 16 - 1943  
that I last saw her alive on Dec. 16 - 1943  
and that death occurred on the date and hour stated above

Immediate cause of death terminal condition  
Chronic Arthritis  
regurgitation of aorto-  
aortic valve

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy Yes

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 A. J. Davis (M. D. or other).....  
Address Dexter, Mo. Date signed 12-17-43

Duration 2 1/2

PHYSICIAN

Underline the cause to which death should be charged statistically.

1137

RECEIVED

District Health Office No. 2,

District File Number 4-43

Date Filed 1-5-44

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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 Hayd W. Fox

Licensed Embalmer No. 2910

P. O. Address Depton 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. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Stoddard  
(b) City or town Rural  
(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 Mary C. Fonville  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 Nov. 3 (Month) (Day) (Year)

8. AGE: Years 81 Months \_\_\_\_\_ Days \_\_\_\_\_ (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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(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 \_\_\_\_\_

20. DATE OF DEATH: Month Dec Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Arthritis  
Deformans (Chronic Hypertension)  
Due to \_\_\_\_\_  
Due to arterio-sclerosis

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

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

S-43990