

No. 27
-5-43
-5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 12 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 199

Primary Registration District No. 5722

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon

(b) City or town rural Marrott
(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 years, months or days)

In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(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.....

3. (a) PRINT FULL NAME Thomas R. Teter

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3- day 18
year 1944 hour 6 minute 30 PM

21. I hereby certify that I attended the deceased from 3-7 to 3-18, 1944
that I last saw him alive on 3-10, 1944
and that death occurred on the date and hour stated above.

4. Sex male

5. Color or race W

6. (a) Single, widowed, married, divorced..... 4

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

7. Birth date of deceased: Nov. 29 - 1860
(Month) (Day) (Year)

Immediate cause of death.....
Prostatic Obstruction 2.0
3 yrs

Duration.....

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|-----------|----------------------|
| <u>83</u> | <u>3</u> | <u>18</u> | hr. min. |

Due to.....

Due to.....

9. Birthplace Macon Co. Mo
(City, town, or county) (State or foreign country)

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

Major findings:
Of operations.....

10. Usual occupation Farmer

Of autopsy.....

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

MOTHER FATHER

11. Industry or business Cain Teter

12. Name Cain Teter

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

14. Maiden name Isabelle Teter

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

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?.....

16. (a) Informant O. Teter

(b) Address Callegemound Mo R.R. 1

While at work?.....
(Specify type of place)

(e) Means of injury.....

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 3-20-44
(Month) (Day) (Year)

(c) Place: burial or cremation Heron Cem. Macon Co

23. Signature C. Smith (M. D. or other)
Address Moberly Mo Date signed 3/23/44

18. (a) Signature of funeral director Stephens & Gooding Mo

(b) Address Macon Mo

19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

1043

RECEIVED

District Health Officer No. 10

District File Number 4-44-724

Date Filed APR 8 1944

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 C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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.

Registration District No. 199

Primary Registration District No. 5722

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Mason
(b) City or town usual manufacturing
(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 _____
In this community Don't know (Specify whether years, months or days)

3. (a) PRINT FULL NAME Thomas R. Jeter

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Nov 2
(Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days _____ If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

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) Apr. 14 1944 (b) W. F. Allen
(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 March 1944 year. 19 hr. 15 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 Prostatic obstruction
Hypertrophy condition duration 2 3 yrs

Due to _____

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 W. Smith (M. D. or other) _____
Address Mobile, MO Date signed 5-1-44

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

SUPPLEMENTARY

11477

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