

S. No. 2
OM-2-43
v. 5-17-39
P-1 X35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11527
State File No. _____
Registrar's No. 21

FILED APR 7 1944

Primary Registration District No. 787

700
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County MISSISSIPPI
(b) City or town CHARLESTON (RURAL)
(c) Name of hospital or institution: R# 3 Insanity
(d) Length of stay: In hospital or institution 5 (Specify whether years, months or days) 16 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County MISSISSIPPI
(c) City or town CHARLESTON (RURAL)
(d) Street No. R# 3 (If rural, give location) 67
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ADDIE GREEN GROSS
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MARCH day 3 year 1944 hour 8 minute 30 AM.
21. I hereby certify that I attended the deceased from Sept 1 1943 to March 5 1944; that I last saw her alive on March 7 1944; and that death occurred on the date and hour stated above.

4. Sex F 1 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED 2
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

Immediate cause of death: Mitral Insufficiency
Due to Ca Breast
Other conditions (Include pregnancy within 3 months of death) 50
Duration 4 wks
2 yrs

7. Birth date of deceased DEC (Month) 7 (Day) 1964 (Year)
8. AGE: Years 79 Months 2 Days 26 If less than one day hr. min.

Other findings: Of operations 50
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace MILTON MO. D (City, town, or county) (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business Retired Housewife
12. Name THOS ANGEL
13. Birthplace N.K. MO. D (City, town, or county) (State or foreign country)
14. Maiden name SARAH ANN PEBBLEY
15. Birthplace MO. D (City, town, or county) (State or foreign country)

MOTHER FATHER {
16. (a) Informant CHARLES MILLER (b) Address R# 3 CHARLESTON, MO.
17. (a) BURIAL (b) Date thereof 3-7 44 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation TARKIO CEMETERY TARKIO MO.
18. (a) Signature of funeral director DAVIS FUNERAL HOME (b) Address TARKIO, MO.
19. (a) Date received local registrar Oct 1-44 (b) Mrs. Lou M... (Registrar's signature)

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) (c) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address Charleston Mo Date signed 3/3/4

1251

RECEIVED

District Health Office No. 2,

District File Number 44-368

Date Filed 4-4-44

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

John F. Nunnelle Jr

Licensed Embalmer No. 3851

P. O. Address Charleston, 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.