

No. 2
8-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 13 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28191
Registrar's No. 364

Registration District No. 184

Primary Registration District No. 3038

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

1. PLACE OF DEATH:

(a) County... Linn
(b) City or town... Brookfield Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Queens Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... 6 mo
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... MO (b) County... Linn 59
(c) City or town... Marceline MO
(If outside city or town limits, write "RURAL")
(d) Street No... _____
(If rural, give location) _____
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CALVIN CUTLER

3. (b) If veteran, name war... no 3. (c) Social Security No... none

4. Sex... Male 5. Color or race... White 6. (a) Single, widowed, married, divorced... Widowed

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

7. Birth date of deceased... Dont know
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
app. 77 hr. min.

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

10. Usual occupation... Retired

11. Industry or business... _____

12. Name... Dont know

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

14. Maiden name... Dont know

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

16. (a) Informant _____ (b) Address _____

17. (a) Burial (b) Date thereof... Aug 27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation... mt Olivet

18. (a) Signature of funeral director... James M Laughlin

(b) Address... Marceline Mo

19. (a) 8-27-44 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27 26
year 1944 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from aug 26
1944 to aug 26 1944
that I last saw him alive on aug 26 1944
and that death occurred on the date and hour stated above.

Immediate cause of death... acute myocarditis Duration 1 day
Due to... arterial hypertension years

Due to... _____

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

Major findings: Of operations... 930

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... H. H. Potter (M. D. or other) o.c.

Address... Brookfield Mo Date signed... 8-27-44

4 SA (Licensed Embalmer's Statement on Reverse Side)

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Body was not embalmed

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(If outside city or town limits write "RURAL" and name of township)
(c) Name of hospital or institution: Owens Conv. Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 mo.
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Calvin Cutler

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 W

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____ If 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 Mrs Mary Owen

(b) Address Brookfield Mo

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) 8-27-44 (b) A W Cowan
(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 Aug Day 26
Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____

that I last saw h. _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

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) _____

(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

MOTHER FATHER

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

28191