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

FILED SEP 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28350

State File No. _____

Registration District No. 234 Primary Registration District No. 5815 Registrar's No. 15

1. PLACE OF DEATH:

(a) County MORGAN

(b) City or town RURAL HAWCREEK Mo
(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:

(a) State MISSOURI (b) County MORGAN

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

(d) Street No. 2 mi. SOUTH OF STOVER
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ELIZABETH REBECCA GEARY

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 21 year 1944 hour 7 minute 25 P.M.

21. I hereby certify that I attended the deceased from July 29 to August 21 1944 that I last saw her alive on August 19 and that death occurred on the date and hour stated above.

Immediate cause of death: Edeema of brain

Due to: Chronic nephritis

Other conditions: crisis of skull - Neuritis (acute)

Major findings: _____

Of operations: _____

Of autopsy: _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased: MARSH 12 1870
(Month) (Day) (Year)

Duration 3 days

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8. AGE: Years 74 Months 5 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace BENTON Co. MO.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name THOMAS GEARY

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

14. Maiden name JANE WISE

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

16. (a) Informant MRS. CHAS. RAPP

(b) Address STOVER MO.

17. (a) BURIAL (b) Date thereof AUG. 23 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BIG BUFFALO CEM

18. (a) Signature of funeral director Rapp, Stover, Mo

(b) Address _____

19. (a) Aug 25 44 (b) Henry Rapp
(Date received local registrar) (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) (e) Means of injury _____

23. Signature J L Washburn (M. D. or other) M.D.
Address Stover Mo Date signed 8/24/44

1680

RECEIVED
DISTRICT HEALTH DEPARTMENT
CITY OF BALTIMORE
8-44-1058
9-12-44

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 J. L. Stevenson
Licensed Embalmer No. 4073
P. O. Address Stover 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: