

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 9 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37904

State File No.

Registration District No. 141

Primary Registration District No. 5554

Registrar's No. 9

460000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Howell
(a) County: Howell
(b) City or town: Rural, Springbrook Twp
(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: 1
(Specify whether
In this community: _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Howell
(c) City or town: Rural, Springbrook
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Martha Jane Tison
3. (b) If veteran, name war: _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 23
year 1944 hour 2 minute 45 a.m.

4. Sex: Female 5. Color or race: W
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: Feb. 22 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan _____, 1944, to Nov. 23, 1944, that I last saw her alive on Nov 1, 1944, and that death occurred on the date and hour stated above.

8. AGE: 74 Years Months 9 Days 1 If less than one day _____ hr. _____ min.

Immediate cause of death: Cerebral hemorrhage
Due to _____
Due to 8:30
Other conditions (include pregnancy within 3 months of death) _____
Major findings: _____
Of operations: _____
Of autopsy: _____

9. Birthplace: _____ (City, town, or county) Virginia (State or foreign country)
10. Usual occupation: house wife
11. Industry or business: _____
12. Name: Abner Lapp
13. Birthplace: _____ (City, town, or county) Virginia (State or foreign country)
14. Maiden name: Donna Brown
15. Birthplace: _____ (City, town, or county) Virginia (State or foreign country)

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

MOTHER FATHER
16. (a) Informant: Martha Tison
(b) Address: Carroll, Mo
17. (a) burial (b) Date thereof: Nov 23 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place of burial or cremation: Central Cemetery
18. (a) Signature of funeral director: W. H. Home
(b) Address: 211 Home Fair
19. (a) 11-23-44 (b) _____
(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? _____
(Specify type of place)
While at work? _____ (c) Means of injury: _____
23. Signature: C. A. Beach M.D.
Address: Elizah, Mo Date signed: 11-23-44

1125

RECEIVED

District Health Officer No. 5,

District File Number 1244599

Date Filed 12-8-44

~~Frank~~
Inachman

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.....

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.