

*Adjoining*

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38357**  
Registrar's No. **82**

FILED NOV 20 1944

2045

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Mississippi  
(b) City or town Charleston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
227 W. Commercial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 50 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Miss  
(c) City or town Charleston  
(If outside city or town limits, write "RURAL")  
(d) Street No. 227 W. Commercial  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None

3. (a) PRINT FULL NAME George David Test  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month October day 24th  
year 1944 hour 7 minute 15 A. M.

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mollie Ketterer Test 6. (c) Age of husband or wife if alive 67 years  
7. Birth date of deceased June 5th 1860  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 14, 1944 to Oct 24, 1944  
that I last saw him alive on Oct 24, 1944,  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
84 4 19 hr. \_\_\_\_\_ min.

Duration  
Coronary occlusion 3 da.  
Myocarditis  
Due to Cardiac hypertrophy  
Other conditions Senility  
(Include pregnancy within 3 months of death)

9. Birthplace Terre Haute Ind.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Merchant

Major findings:  
Of operations none 93%  
Of autopsy none  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name David Test  
13. Birthplace N.K. Ind.  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Saberton  
15. Birthplace N.K. Ind.  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Test  
(b) Address 227 W. Commercial Charleston  
Burial (b) Date thereof 10-26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Mode 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? \_\_\_\_\_

(c) Place: burial or cremation Calvary Charleston, Mo.  
18. (a) Signature of funeral director John F. ...  
(b) Address 1111 1/44  
19. (a) 11/1/44 (b) Mrs. Lou Mae  
(Date received local registrar) (Registrar's signature)

(Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature Chas. ... (M. D. or other) \_\_\_\_\_  
Address Charleston, Mo. Date signed 10/30/44

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

MOTHER FATHER

1257

RECEIVED

District Health Office No. 2,

District File Number 114-1544

Date Filed 11-15-44

JUN 18 1945

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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. Munnell 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.