

S. No. 2
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P-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41787**

Registration District No. **271**

Primary Registration District No. **5911**

Registrar's No. _____

1. PLACE OF DEATH

(a) County Pennsacot
(b) City or town Rural Passola Twp
(If outside city or town limits, write "RURAL" and name of township)
(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 none
(Specify whether
In this community 9 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pennsacot
(c) City or town Rural Passola Twp
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joe Cross

3. (b) If veteran name war No 3. (c) Social Security No. _____

4. Sex F 3 5. Color or race col 6. (a) Single, widowed, married, divorced single

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

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

8. AGE: Years abt 72 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation laborer

11. Industry or business _____

12. Name unknown

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 Letter Hallaway

(b) Address Passola Mo

17. (a) Burial (b) Date thereof 12-28-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cem

18. (a) Signature of funeral director Arthur Funeral Home
(b) Address St. Louis Mo.

19. (a) 12-29-44 (b) Mrs P.R. Cole
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 23
year 1944 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from on
12-4- 1944 to _____, 19____;
that I last saw him alive on 12-4-44, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Heart Disease Duration _____

Due to _____

Due to _____

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

Major findings: Of operations 92d

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 2

23. Signature J.P. Masters (Date of death)

Address Waymo Mo Date signed 12-27-44

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

8000

591

(Licensed Embalmer's Statement on Reverse Side)

1244 - 273

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 H. Gorman

Licensed Embalmer No. 4355

P. O. Address St. Louis, Mo. Box 71

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.