

FILED MAR 29 1945

STANDARD CERTIFICATE OF DEATH

10422

State File No. ....

Registration District No. 275

Primary Registration District No. 2053

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Phelps  
(b) City or town Rolla  
(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 7 days (Specify whether)  
In this community 20 yr (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps  
(c) City or town Newburg Mo  
(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 .....

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Wilma Mae Null

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

20. DATE OF DEATH: Month Mar day 24  
year 1945 hour 25 minute - M.

21. I hereby certify that I attended the deceased from  
Mar 17 - 1945 to Mar 24 1945  
that I last saw her alive on Mar 24  
and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race white  
6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Donald B. Null  
6. (c) Age of husband or wife if alive 25 years  
7. Birth date of deceased Sept 27 1925 (Month) (Day) (Year)

Immediate cause of death Myo. Endo carditis  
Duration

8. AGE: Years 19 Months 5 Days 26 If less than one day hr. min.

Due to .....  
Due to ..... 910

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

Other conditions Disturb in delivery pregnancy (Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Disturb delivery & brow presentation  
Of operations .....  
Of autopsy None

MOTHER FATHER

11. Industry or business  
12. Name Floyd Courson  
13. Birthplace Arlington Mo (City, town, or county) (State or foreign country)  
14. Maiden name Josephine Laughridge  
15. Birthplace Arlington Mo (City, town, or county) (State or foreign country)

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?

16. (a) Informant Floyd Courson  
(b) Address Newburg Mo  
17. (a) Burial (b) Date thereof Mar 27 1945 (Month) (Day) (Year)  
(c) Place: burial or cremation Rolla Mo

While at work? (Specify type of place) (c) Means of injury .....  
23. Signature R.E. Brewer (M. D. or other)  
Address Newburg Mo Date signed 3/27/45

18. (a) Signature of funeral director Geo. Johnson  
(b) Address Newburg Mo  
19. (a) 3-24-1945 (Date received local registrar) (b) Walter Walker (Registrar's signature)

1092

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

**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.....

*L*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Lee Johnson*.....

Licensed Embalmer No. *3392*.....

P. O. Address *Newburg 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.**

Registration District No. 275

Primary Registration District No. 3053

Registrar's No. ....

1. PLACE OF DEATH:

(a) County P Phelps  
(b) City or town Rolla  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Miss McFarland Mem'l Ho  
(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)

3. (a) PRINT FULL NAME Wilma Mae null  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_  
5. Color or race \_\_\_\_\_  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
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 \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Unless than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
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 \_\_\_\_\_  
(b) Address \_\_\_\_\_

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) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 March day 14  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

10422