

S. No. 2  
OM-2-43  
v. 5-17-39  
X35897

21507

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JUN 13 1945**  
STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. 336

Primary Registration District No. 637

Registrar's No. \_\_\_\_\_

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

**1. PLACE OF DEATH:**

(a) County Shannon

(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Anna Inf  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community Life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Shannon

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

(d) Street No. Anna Inf  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Louisa C. Short

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 23  
year 1945 hour 12 minute 30 P.M.

4. Sex F 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: July 16 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9-18, 1941, to 4-12, 1945  
that I last saw her alive on 4-12, 1945  
and that death occurred on the date and hour stated above.

**8. AGE:**

| Years     | Months   | Days     | If less than one day |
|-----------|----------|----------|----------------------|
| <u>83</u> | <u>9</u> | <u>7</u> | hr. _____ min. _____ |

Immediate cause of death Gastric Carcinoma 2 yrs.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

10. Usual occupation Housekeeper

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

Major findings: Of operations Hx  
Of autopsy \_\_\_\_\_

**11. Industry or business**

12. Name Henry Mitchell

13. Birthplace Castles Co. Mo.  
(City, town, or county) (State or foreign country)

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

14. Maiden name Sarah Patterson

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

16. (a) Informant Mrs Ethel Sommers  
(b) Address Law Wessie Mo.

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? \_\_\_\_\_

(a) Place: burial or cremation deceased life

18. (a) Signature of funeral director Thilda Tenchel  
(b) Address Van Rural Mo.

19. (a) 5-4-45 (b) Frank Hyde, M.D.  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (c) Means of injury

23. Signature Frank J. Reinsch M.D. or other D.O.  
Address Van Rural Mo. Date signed 4-24-45

744

RECEIVED

District Health Officer No. 5,

District File Number

645-296

Date Filed

6-16-45

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 4-23-45

Registered Apprentice No.

working under my personal supervision.

Signed

Philip A. Leuchel

Licensed Embalmer No. 2936

P. O. Address Van Buren 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.