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M-8-43  
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K37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27058

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

FILED SEP 12 1945  
Registration District No. \_\_\_\_\_

Primary Registration District No. 4091

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

1. PLACE OF DEATH:  
(a) County Carter  
(b) City or town Jeremont  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Carter 18  
(c) City or town Jeremont 0  
(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 MARY HELEN GIBBS  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 25 year 1945 hour 2 minute 10 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

21. I hereby certify that I attended the deceased from 11-26 1944 to 7-25 1945 that I last saw her alive on 7-21 1945 and that death occurred on the date and hour stated above.

7. Birth date of deceased July 3 1858  
(Month) (Day) (Year)  
8. AGE: Years 87 Months 0 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death auricular skullation  
due to + Bright's disease  
Duration 5 yrs.

9. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
10. Usual occupation invalid

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Samuel Hoagland  
13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Katie Weekley  
15. Birthplace unknown 0  
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Elzadie Martin  
(b) Address Jeremont Mo  
17. (a) Burial (b) Date thereof 9-29-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Jeremont Cemetery  
18. (c) Signature of funeral director W. B. Breen  
(b) Address Jeremont Mo  
19. (a) 7/28 1945 (b) Mrs B. G. Smith  
(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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 2  
23. Signature Frank Rucinski (D.O. or other) D.O.  
Address Jeremont Mo Date signed 7-19-45

**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 7-25-45

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

Signed Philip A. Louchel  
Licensed Embalmer No. 2936  
P. O. Address Van Buren Ave

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept  
Registrar's No. \_\_\_\_\_

Registration District No. 58 Primary Registration District No. 4091

1. PLACE OF DEATH:  
(a) County Carter  
(b) City or town Fremont  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Mary H. Gibbs  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased July 3 (Month) (Day) (Year)  
8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

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

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(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 \_\_\_\_\_ Year 1945 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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)  
Major findings: Chronic Nephritis  
Of operations \_\_\_\_\_  
Of autopsy BIK

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 Frank J. Pasinski (M. D. or other) D.O.  
Address Van Horn, Mo. Date signed 10-3-45

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

MOTHER FATHER

SUPPLEMENTARY

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-27058