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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 18 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30756

Registration District No. 157 Primary Registration District No. 5587 Registrar's No. 177

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:
R# 2, Carthage, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 45 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

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

(d) Street No. R# 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME NETTIE BELLE FROST

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife George Wilbur Frost

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased August 25 (Month) 1882 (Day) (Year)

8. AGE: Years 64 Months 0 Days 6 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name ~~Galloway~~ Galloway
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Nettie Beall
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant George Wilbur Frost
(b) Address R#2, Carthage, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 3, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Paradise Cemetery

18. (a) Signature of funeral director Ed C. Ulmer
(b) Address Carthage, Mo.

19. (a) 8-31-46 (Date received local registrar) (b) L. B. Clinton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31st year 1946 hour 12 minute 40 A.M.

21. I hereby certify that I attended the deceased from July, 1944 to August 30th 1946 that I last saw her alive on August 30th 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Heart failure	
Due to Asthma condition	1 year
Other conditions (Include pregnancy within 3 months of death)	

112

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

NMI

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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature D. Guldner (M. D. or other)
Address Lamar, Mo. Date signed 8/31/46

139

(Licensed Embalmer's Statement on Reverse Side)

46-8-719

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.....Ed [illegible]

Licensed Embalmer No.....2222

P. O. Address.....Carthage

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—3-45
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STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 157 Primary Registration District No. 5587 Registrar's No. 177

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Rural
(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)

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

3. (a) PRINT FULL NAME Nettie B. Frost

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 M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive year

7. Birth date of deceased Aug (Month) 25 (Day) 88 (Year)

8. AGE: Years 64 Months 0 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 31 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No Info.
Dr. [illegible]

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

29588

30756