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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Hogan
State File No. **8841**

FILED MAR 31 1947
Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 49

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

1. PLACE OF DEATH:

(a) County Howell

(b) City or town West Plains

(c) Name of hospital or institution: Christa Hogan Hospital (If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 3 days (If not in hospital or institution, write street number or location)

In this community 65 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howell

(c) City or town Mountain View (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 John H. Bird

3. (b) If veteran, name war no

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

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

7. Birth date of deceased: March 25 1881 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>10</u>	<u>23</u>	hr. _____ min.

9. Birthplace Mountain View - Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Saw Mill Worker

11. Industry or business _____

MOTHER FATHER

12. Name Kay Bird

13. Birthplace unknown (City, town, or county) (State or foreign country)

14. Maiden name Frances Miller

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

16. (a) Informant Claud Bird

(b) Address Mtn. view, Mo.

17. (a) Burial (Burial, cremation, or removed)

(b) Date thereof 2-20-47 (Month) (Day) (Year)

(c) Place: burial or cremation Mtn View City Cemetery

18. (a) Signature of funeral director J. R. Williams

(b) Address Mountain View, Mo.

19. (a) 3-18-47 (Date received local registrar)

(b) Beatrice Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18 year 1947 hour 2 minute 30 p.m.

21. I hereby certify that I attended the deceased from 2/15 1947, to 2/18 1947; that I last saw him alive on 2/18 1947; and that death occurred on the date and hour stated above.

Immediate cause of death: Internal Injuries

Due to Crushed Chest

Due to Car accident

Other conditions (Include pregnancy within 3 months of death)

Major findings: 170C-8 #28

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) automobile accident

(b) Date of occurrence 2/15/47

(c) Where did injury occur near Mt. View-Howell-Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? public place

While at work no (Specify type of place) (e) Means of injury automobile

23. Signature Hogan

Address West Plains, Mo. Date signed _____

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 347163

Date Filed 3-28-47

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.....

Robert J. Mayo

working under my personal supervision.

Registered Apprentice No. 432

Signed *Robert J. Mayo*

Licensed Embalmer No. 3432

P. O. Address Metairie, 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.