

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Case No. 14772

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

FILED APR 18 1947

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 120

1. PLACE OF DEATH:

(a) County St. Francois

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

(c) Name of hospital or institution: None Rural  
(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 Missouri (b) County St. Francois

(c) City or town Esther  
(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 Nancy Cain

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28  
year 1947 hour 1:15 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Jan 1  
1947 to March 28, 1947  
that I last saw her alive on Mar 26, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral myocarditis Duration \_\_\_\_\_

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife George W. Cain

6. (c) Age of husband or wife if alive 89 years

7. Birth date of deceased Sept 15 1858  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>89</u>	<u>6</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Self

MOTHER FATHER

12. Name Jim Marlar

13. Birthplace Washington County, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant L. Latene Jones

(b) Address Plevy, Mo.

17. (a) Burial (b) Date thereof Mar-30-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Falls CEM.

18. (a) Signature of funeral director Spa. Hs. Funeral Home

(b) Address 300 Taylor Flat River, Mo.

19. (a) 4-15-47 (b) Esther Rudloff  
(Date received local registrar) (Registrar's signature)

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

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

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? 0

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

(b) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MD

Address [Address] Date signed 4.1.47

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

RECEIVED

District Health Officer No. 4  
District File Number 447-563  
Date Filed 4-21-42

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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 Murphy L. Sparta  
Licensed Embalmer No. 4236  
P. O. Address Flat River 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.