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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JUN 25 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21527

Registration District No. 178

Primary Registration District No. 4284

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Barren, MO
(b) City or town Osborne, MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 MO (b) County Barren
(c) City or town Osborne, MO
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1947 hour 5 minute 50P.M.

21. I hereby certify that I attended the deceased from April 20 1947 to June 16 1947
that I last saw her alive on June 10, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach
Duration 29 years

Due to _____
Due to _____

Other conditions Sanity
(Include pregnancy within 3 months of death)

Major findings: 46
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? _____

While at work? _____ (Specify type of place)
(c) Means of injury car
23. Signature Jerry M. Brockman (M. D. or other) MD
Address Osborne, MO Date signed June 18

3. (a) PRINT FULL NAME LEVICIE MEDARIS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Chas. F. Medaris 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Feb 3 (Month) 1866 (Day) (Year)

8. AGE: Years 81 Months 4 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer, Retired

11. Industry or business _____

12. Name Robert Davis

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

14. Maiden name Donna Krampf

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

16. (a) Informant Chas. F. Medaris
(b) Address Osborne, MO

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof June 18 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Osborne, MO

18. (a) Signature of funeral director W. J. ...
(b) Address _____

19. (a) 6/25/47 (Date received local registrar) (b) W. J. ... (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 1

District File Number 647-776

Date Filed JUN 23 1947

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.....

Geo. V. Bosker

Licensed Embalmer No.

1517

P. O. Address.....

Wynconda

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *July*Registrar's No. *618*Registration District No. *178*Primary Registration District No. *4284*

1. PLACE OF DEATH:

(a) County *Lewis*
(b) City or town *La Belle*
(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 *Lewice Medaris*

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 _____ years

7. Birth date of deceased *Feb 3 1866*
(Month) (Day) (Year)8. AGE: Years *81* Months _____ Days _____ (Less than one day) _____ hr. _____ min.

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

10. Usual occupation:

11. Industry or business *Retired farmer*

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 _____ Day _____ Year *1946* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ 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:

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

S-21527