

S. No. 2  
DM-8-43  
v. 5-17-39  
I X37823

28802

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED SEP 9 1947

Registration District No. 316

Primary Registration District No. 6074

Registrar's No. 298

1. PLACE OF DEATH:

(a) County St. Francois

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

(c) Name of hospital or institution:  
None  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community 30 years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois <sup>94</sup>

(c) City or town Leadwood, Missouri <sup>0</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. none <sup>0</sup>  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) <sup>0</sup>

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Angie Talley

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27  
year 1947 hour 2 minute \_\_\_\_\_ P. M.

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Hubert Talley

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased January 6 1882  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 1947 Aug 25 1947  
that I last saw her alive on Aug 25 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 1 week

8. AGE: Years Months Days If less than one day

65 7 21 hr. \_\_\_\_\_ min.

Due to Hypertensive Cardiovascular disease years

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

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

10. Usual occupation housewife

11. Industry or business none

Other conditions Cerebral hemorrhage 6 Mos.  
(Include pregnancy within 3 months of death)

MOTHER FATHER

12. Name Charles Cooper

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

14. Maiden name Susan Queen

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

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

Of autopsy 93D

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Hubert Talley

(b) Address Leadwood, Missouri

17. (a) Burial (b) Date thereof 8/29/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leadwood, Missouri

18. (a) Signature of funeral director Bert L. Boyer  
Leadwood, Missouri

(b) Address \_\_\_\_\_

19. (a) 8-30-47 (b) Ether Rudloff  
(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 \_\_\_\_\_

23. Signature J. L. Foster (M. D. or other) \_\_\_\_\_  
Desloge MO Address \_\_\_\_\_ Date signed 8-29-47

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

RECEIVED

Health Officer No. 4

File Number 947-1148

Date 9-8-47

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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 Bert L. Boyer

Licensed Embalmer No. 3445

P. O. Address Leadwood 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.