

No. 2
MOM-5-43
ev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42326**

FILED DEC 26 1947
Registration District No. **281**

Primary Registration District No. **4315**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **MACON**

(b) City or town **LA-PLATA**
(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 **WILLIAM-FOSTER-VOSE**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **WHITE**

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

6. (b) Name of husband or wife **EDITH-VOSE**

6. (c) Age of husband or wife if alive **39** years

7. Birth date of deceased **OCTOBER 24 - 1908**
(Month) (Day) (Year)

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

39 **1** **1** _____ hr. _____ min.

9. Birthplace **MACON-COUNTY MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABOR**

11. Industry or business _____

MOTHER FATHER { 12. Name **FRANKLIN-VOSE**

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

14. Maiden name **JOANNA-TUCKER**

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

16. (a) Informant **EDITH-VOSE**

(b) Address **LA-PLATA, MO.**

17. (a) **BURIAL** (Burial, cremation, or removal)

(b) Date thereof **NOV. 28 - 1947**
(Month) (Day) (Year)

(c) Place: burial or cremation **LA-PLATA-MO.**

18. (a) Signature of funeral director **M. B. McCallum**

(b) Address **South Highland St.**

19. (a) **Dec 8-47** (Date received local registrar)

(b) **Mrs O B Griffin** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **MACON**

(c) City or town **LA-PLATA**
(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 **NOV.** day **25**
year **1947** hour **2** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Oct. 3, 1947** to **Nov. 25, 1947**
that I last saw him alive on **Nov. 24, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Interstitial Nephritis**

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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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 **0**

23. Signature **E. H. Buckley** (M. D. or other)

Address **La Plata Mo.** Date signed **11-26-47**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SEP 18 1956

RECEIVED
District Health Officer No. 10
District File Number 12-41-1807
Date Filed DEC 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 Clyde W. Collins

Licensed Embalmer No. 3226

P. O. Address Clines, 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.