

No. 2
1747
1736

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17345

National Office of Vital Statistics
FILED MAY 27 1948

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 153

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Esther, Mo
(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)

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 Myrtle M. Wood

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, Widowed
6. (b) Name of husband or wife John Wood 6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased March 14 1902
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 2 0 ..hr.min.

9. Birthplace Flat River, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

12. Name Nick Mason
13. Birthplace Bonne Terre, Mo (City, town, or county) (State or foreign country)
14. Maiden name Katie Cain
15. Birthplace Iron County, Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Velva Kennon
(b) Address Leadington, Mo

17. (a) Burial (b) Date thereof May-17-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Falls Ceme

18. (a) Signature of funeral director Sparks
(b) Address Flat River, Mo

19. (a) 5-19-48 (b) Esther Rudloff
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1948 hour 2:20 minute P.M.

21. I hereby certify that I attended the deceased from 8-12-47, 1947, to 5-14, 1948
that I last saw h. per alive on 5-6, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death inoperable carcinoma of abdomen
Duration

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN Underline the cause of 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?.....
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature Esther Rudloff (M. D. or other).....

Address 501 E. St. Jerome Date signed 5-19-48

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

MOTHER FATHER

44

0

0

1

P.M.

8-12-47

5-14

1948

5-6

1948

Duration

Due to.....

Due to.....

Other conditions.....

Major findings:

Of operations.....

Of autopsy.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN Underline the cause of 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?.....

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

While at work?.....

23. Signature Esther Rudloff (M. D. or other).....

Address 501 E. St. Jerome Date signed 5-19-48

RECEIVED

District Health Officer No. 4
District File Number 548-669
Date Filed 5-26-48

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. Parks

Licensed Embalmer No.

4536

P. O. Address

East 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *June*Registration District No. *316*Primary Registration District No. *6071*Registrar's No. *15-3*

1. PLACE OF DEATH:

(a) County *St Francis*
(b) City or town *Cathlamet*
(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 days3. (a) PRINT
FULL NAME *Meyrtle M. Wood*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 *wid*

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased *March 14 1904*

(Month)

(Day)

(Year)

8. AGE:

Years *46*Months *2*Days *11*

If less than one day

_____.hr. _____.min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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 _____
year *1950* 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 *adverse conditions* Duration _____
of service

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 sta-
tistically.

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)

23. Signature *W. H. Thompson* (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-17345