

No. 2  
-8-43  
-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26990

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

FILED SEP 2 1948  
Registration District No. 289

Primary Registration District No. 4315

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Wagon

(b) City or town Wagon  
(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 79 years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Rural 11000  
(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 GERTIE-MAY-DOBRINS

MEDICAL CERTIFICATION

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

3. (c) Social Security No. ✓

20. DATE OF DEATH: Month Aug day 21  
year 1948 hour 12:30 minute 0 M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

21. I hereby certify that I attended the deceased from May 20, 1948 to Aug 21, 1948  
that I last saw her alive on Aug 18, 1948  
and that death occurred on the date and hour stated above.

6. (b) Name of husband or Emmit 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Nov 10 1877  
(Month) (Day) (Year)

Immediate cause of death Carcinoma of liver

Duration 9.7K

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>9</u>	<u>11</u>	hr. _____ min. _____

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

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

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

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

Major findings: Of operations 46K

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

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Wm. Morris Jones

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

14. Maiden name Sophia Fairchild

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

16. (a) Informant Mrs. Bertha Holmes

(b) Address 838 An-ave K.C. Mo

17. (a) Burial (b) Date thereof Aug 23 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Steel Cemetery

18. (a) Signature of funeral director D. S. Christ

(b) Address La Plata Mo

19. (a) Aug 23 1948 (b) Wm. B. Miller  
(Date received local registrar) (Registrar's signature) 1760

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? \_\_\_\_\_

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

23. Signature C. H. Quessy (M. D. or other) \_\_\_\_\_  
Address La Plata Mo Date signed 8-21-48

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

MOTHER FATHER

NOV 10 1949

RECEIVED

District Health Officer No. 10

District File Number 9-48-154

SEP 1 - 1948

Date Filed \_\_\_\_\_

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 M. H. McCallister

Licensed Embalmer No. 2052

P. O. Address South Gifford St

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.