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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39347**

FILED DEC 16 1948

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **309**

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

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution:
Parson Rest Home #4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days
(Specify whether years, months or days)

In this community 15 days

3. (a) PRINT FULL NAME KATHERINE WESLEY

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

4. Sex Fe 3 5. Color or race Col

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

6. (b) Name of husband or wife unknown (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>about</u>		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 Henry Watson

(b) Address Marshall, Mo.

17. (a) Removal (b) Date thereof 12 4 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall, Mo.

18. (a) Signature of funeral director Green & Sons

(b) Address Marshall, Mo.

19. (a) 12-4-48 (b) Mrs R.E. Palmer
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jasper

(c) City or town Marshall
(If outside city or town limits, write "RURAL")

(d) Street No. Corner West 3rd & Sumner
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day * 3
year 1948 hour 5 minute 00 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown

Due to Believed to be

Due to Heart disease

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

Major findings: Of operations _____

Of autopsy 95 - C.

Duration _____

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)

Means of injury _____

23. Signature [Signature] (or other) _____

Address Columbia, Mo. Date signed 12/3/48

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed
DEC 15 1948

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.....
Licensed Embalmer No. 4225
P. O. Address.....

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.