Dailing Hailt Or Commence	7 /1 L- 1 /	1
Registration District No. 135 Primary Registration Distri	rict No. 30 10 Registrar's No. 10 7	*******
(a) County (b) City or town (If outside city or town limits, write "RURAL" and name of township) (c) Name of 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 Out I Vernille Out Specify whether FULL NAME Out I Vernille Out I Ve	2. USUAL RESIDENCE OF DECEASED: (a) State Marini (b) County College (c) City or town (If outside city or town limits, write "RURAL") (d) Street No. 608 N Marini (e) Citizen of foreign country? (Yes If yes, name country MEDICAL CERTIFICATION 20. DATE OF DEATH; Month day 25	or No)
5. Color or 6. (a) Single, widowed, married, divorced div	21. I hereby certify that I attended the deceased from 8-3-4 that I last saw h. 2 alive on 10-2 5 and that death occurred on the date and hour stated above. Immediate cause of death. Due to 144 parts of 8-3-4 Due to 15-4 Due to 15-4	1941; 1941; ration
10. Usual occupation 11. Industry or business 12. Name	(Include pregnancy within 3 months of death) Major findings: Of operations. Unterpresent of autopsy. Other within the following: (a) Accident, suicide, or homicide (specify). (b) Date of occurrence. (c) Where did injury occur? (City or town) (County) (Sounty) (Modification of place) While at work? Of autopsy. (Specify type of place) (Means of injury. Of autopsy. Address. Address. Address. Date signed!	
	Registration District No. 35 Registration District No. 35 Primary Registration District No. 35 Primary Registration District No. 35 Primary Registration District No. 36 (If oot in hospital or institution: (If oot in hospital or institution. (Specify whether In this community. 1997) (a) Length of stay: In hospital or institution. (Specify whether In this community. 1997) 3. (a) PRINT Out No. 3. (c) Social Security No. 4. Sex 1997 4. Sex 1997 5. Color pr 1997 6. (a) Single, widowed, married, divorced No. 1997 4. Sex 1997 6. (b) Name of husband or wife 1997 7. Birth date of deceased 1997 8. AGE: Years Months Days If less than one day 1997 19. Birthplace (City, town, or county) (State or foreign country) 10. Usual occupation 11. Industry or business 1997 11. Industry or business 1997 12. Name (City, town, or county) (State or foreign country) 11. Industry or business 1997 13. Birthplace (City, town, or county) (State or foreign country) 11. Birthplace (City, town, or county) (State or foreign country) 11. Industry or business 1997 12. Name (City, town, or county) (State or foreign country) 11. Industry or business 1997 13. Birthplace (City, town, or county) (State or foreign country) 11. Industry or business 1997 14. Maiden name (City, town, or county) (State or foreign country) 11. Industry or business 1997 15. (a) Informant (Burial director (Month) (Day) (Year) (Pace) (Month) (Day) (Year) 1997 16. (a) Informant (Burial director (Month) (Day) (Year) 1997 17. (a) Address (Month) (Day) (Year) 1997 18. (a) Signature of funeral director (Month) (Day) (Year) 1997 19. (a) Document (Burial director (Month) (Day) (Year) 1997 (b) Address (Month) (Day) (Year) 1997 (c) Place: burial or cremation (Month) (Day) (Year) 1997 (c) Place: country (Burial director (Month) (Day) (Year) 1997 (d) Address (Month) (Day) (Registrer's signature) 1997	Registration District No. 35 I. PLACE OF DEATH (a) County. (b) City or town. (ff contaids efty or two is limits, write "RUBAL" and some of township) (c) Name of hospital or institution: (d) Length of says: In hospital or institution. (d) Street No. 25 If yes, name country? If yes, name country If yes, name country In this community. In this community. In that say in Length of the says: In hospital or wife. In the says: In hospital or wife. In the says in hospital or wife in the says in hospital or wife. In the says in hospital or wife in the says in hospital or says in hospital or wife in the says in hospital or wife in th

FIVED Health Officer No. 8,

STATEMENT BY LICENSED EMBALMER

working under my personal supervision.

gned AM Marshall

P. O. Address Carriel

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complethe above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH 5. No. 2B State File No.3 4 5 7/ DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS 6M-8-21-41 STANDARD CERTIFICATE OF DEATH ⇒1 X29288 Primary Registration District No. 3016 Registration District No 135 Registrar's No. 1. PLACE OF DEATH: 2. USUAL RESIDENCE OF DECEASED: (a) County..... PERMANENT RECORD (b) City or town. (If outside city or town limits, write "RURAL" and name of township) (c) City or town (If outside city or town limits, write "RURAL") (c) Name of hospital or institution: (d) Street No..... (If not in hospital or institution, write street number or location) (If rural, give location) (d) Length of stay: In hospital or institution..... (Specify whether (e) Citizen of foreign country?......(Yes or No) In this community... years, months or days) If yes, name country..... MEDICAL CERTIFICATION 3. (a) PRINT **FULL NAME** 20. DATE OF DEATH: Mon O 3. (b) If veteran. 3. (c) Social Security name war..... DA. 21. I hereby certify that i serended the 5. Color or 6. (a) Single, widowed, married divorced 6. (b) Name of husband or wife....... 6. (c) Age of hysband or wife if and that death occurred on the date and hour stated above. Duration alive. 7. Birth date of deceased (Day) 8. AGE: Years Uf less than one day Months Days 9. Birthplace (State or foreign country) Other conditions..... 10. Usual occupation (Include pregnancy within 3 months of death) 11. Industry of busines PHYSICIAN Major findings: 12. Name. Of operations. Underline the cause to 13. Birthplace. which death (City, town, or county) (State or foreign country) should be 14. Maiden name... charged sta-15. Birthplace.. 22. If death was due to external causes, fill in the following: (City, town, or county) (State or foreign country) (a) Accident, suicide, or homicide (specify) 16. (a) Informant (b) Date of occurrence..... (c) Where did injury occur?.... (Burial, cremation, or removal) (Month) (Day) (Year) (City or town) (County) (d) Did injury occur in or about home, on farm, in industrial place, in public place? (c) Place: burial or cremation... (Specify type of place)
While at work?..... (e) Means of injury...... 18. (a) Signature of funeral director...... 23. Signature (M. D. or other) Address. (Date received local registrar) (Registrar's aignoture)

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