

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31132**

FILED OCT 13 1944

Registration District No. **758**

Primary Registration District No. **5579**

Registrar's No. **22**

1. PLACE OF DEATH:

(a) County **Jasper**

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

(c) Name of hospital or institution: **Jasper Co TB Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 months**
(Specify whether years, months or days) **0**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**

(c) City or town **Wheaton**
(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 **1**

3. (a) PRINT FULL NAME **Georgia E. Heggs**

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

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **29**
year **1944** hour **6** minute **45 P** M.

4. Sex **21** 5. Color or race **M** 6. (a) Single, widowed, married, divorced **Widow**

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

7. Birth date of deceased **Oct 28 - 1883**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 28**, 19**44**, to **Sept 28**, 19**44**, that I last saw **her** alive on **Sept 28**, 19**44**, and that death occurred on the date and hour stated above.

8. AGE: Years **60** Months **11** Days **0** If less than one day _____ hr. _____ min.

Immediate cause of death **Pulmonary Tuberculosis** Duration _____

9. Birthplace **Wheaton Mo**
(City, town, or county) (State or foreign country)

Due to _____

Due to **1361**

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

10. Usual occupation **Housewife**

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name **Oliver Bratten**

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

14. Maiden name **Billie Roberts**

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

16. (a) Informant **Records**

(b) Address _____

17. (a) **Burial** (b) Date thereof **10-1-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wheaton, Mo**

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? _____

18. (a) Signature of funeral director **Wm. Madis**

(b) Address **Wheaton, Mo**

19. (a) **Oct 1, 1944** (b) **Mrs. Billie Sage**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury **1**

23. Signature **James E. Dancyfon** (M. D. **Mo**)
Address **Wheaton, Mo** Date signed **9/28/44**

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

1180

OCT 17 1944

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.....

Wm Morris Payne

Licensed Embalmer No. *3492*

P. O. Address *Wheaton, 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.