

S. No. 2
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5-17-39
P 1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED APR 8 1946 STANDARD CERTIFICATE OF DEATH

State File No. 10228

Registration District No. 243

Primary Registration District No. 4363

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Fairview
(c) Name of hospital or institution: None
(d) Length of stay: In hospital or institution _____
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton
(c) City or town Fairview, Mo.
(d) Street No. _____
(e) Citizen of foreign country? _____

3. (a) PRINT FULL NAME Louisa Jane Fly

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

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

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

7. Birth date of deceased June 4 1866

8. AGE: Years 79 Months 8 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Missouri

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name D. C. Fly

13. Birthplace Missouri

14. Maiden name Margaret Woodward

15. Birthplace Missouri

16. (a) Informant Mrs W. S. Francis

(b) Address Fairview, Missouri

17. (a) Burial (b) Date thereof 2 16 46

(c) Place: burial or cremation Mt. Pleasant Cem.

18. (a) Signature of funeral director Wm. Morris

(b) Address Wheaton, Mo.

19. (a) 3-21-1946 (b) Orla Tanner by Mrs.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 14
year 1946 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb - 18 - 1946 to Feb 14 - 1946
that I last saw her alive on Feb - 11 - 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chromia Myocarditis

Other conditions _____
Major findings: Of operations _____
Of autopsy _____

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? _____

23. Signature O. S. McCall (M. D. or other) _____
Address Wheaton Mo. Date signed 2/15/46

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

9150

33

9300

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

221

RECEIVED

District Health Officer No.

District File Number 446-47

Date Filed APR 5 1946

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. 3442

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.