

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28275

Registration District No. 297

Primary Registration District No. 6021

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Ray 11

(b) City or town Grape Grove ms
(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 years, months or days)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 89

(c) City or town _____
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Geneva Rosetta Rhea

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th year 1945 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec, 1944 to Aug 6, 1945 that I last saw him alive on Aug 7, 1945 and that death occurred on the date and hour stated above.

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

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

7. Birth date of deceased July 22 1869
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis Duration ?

Due to _____

Due to _____

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

8. AGE: Years Months Days If less than one day

76 0 15 hr. _____ min.

9. Birthplace Ray County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Major findings: Of operations none

Of autopsy none

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

MOTHER, FATHER { 11. Industry or business _____

12. Name Alexander Smith

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

14. Maiden name Susan C. Mays

15. Birthplace Unknown 11
(City, town, or county) (State or foreign country)

16. (a) Informant Joe Henderson

(b) Address Cowgill, Missouri.

17. (a) Burial (b) Date thereof 8--8-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cowgill Cemetery

18. (a) Signature of funeral director Cramer Clark

(b) Address Kingston, Missouri.

19. (a) Aug 14 1945 (b) Mrs. Shus W. Shppard
(Date received local registrar) (Registrar's signature)

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 Geo. S. Dowell (M. D. or other) _____
Address Cowgill, Mo. Date signed Aug 8-45

1280

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Health Officer No. 8

Crit. File Number

Date Filed

9-11-45

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 Cramer Clark

Licensed Embalmer No. 3257

P. O. Address. KINGSTON, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. SeptRegistration District No. 297Primary Registration District No. 6021Registrar's No. 7

1. PLACE OF DEATH:

(a) County Ray
 (b) City or town Shreve Grove, Mo.
 (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
years, months or days)3. (a) PRINT
FULL NAMEGenevieve Rhea3. (b) If veteran,
name war3. (c) Social Security
No.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married,
divorced Wid

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

7. Birth date of deceased July 22 1906
(Month) (Day) (Year)

8. AGE: Years Months Day (If less than one day)
76 hr. min.

9. Birthplace MO
(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
 (b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
 (c) Place: burial or cremation

18. (a) Signature of funeral director
 (b) Address

19. (a) (Date received local registrar) (b) Mrs. Chas W. Shippard
 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
 (c) City or town Cowgill, Mo. RURAL
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec
 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
 to
 that I last saw him alive on
 and that death occurred on the date and hour stated above.
 Immediate cause of death

Duration

Due to
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations

Of autopsy

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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) (e) Means of injury

23. Signature (M. D. or other)
 Address Date signed

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

SUPPLEMENTARY

S-28275

OCT 25 1946

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