

No. 7
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42272

FILED JAN - 7 1943
Registration District No. 888-367

Primary Registration District No. 6178 6246

State File No. _____
Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Washington

(b) City or town Prussdale
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County Washington

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

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

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

3. (a) PRINT FULL NAME MALISA J LASHLEY

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 _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Nov 2 - 1889
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 19 If less than one day hr. _____ min. _____

9. Birthplace Indiana (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation House wife

11. Industry or business Farming

12. Name Daniel Firebaugh

13. Birthplace Indiana (City, town, or county) _____ (State or foreign country) _____

14. Maiden name Abigail Conner

15. Birthplace Indiana (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant Maynard Jackson

(b) Address Brunswick St

17. (a) Burial (b) Date thereof 12 27 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mapleton Co White Hill

18. (a) Signature of funeral director _____
(b) Address Brunswick St

19. (a) 12-30-42 (b) Mrs J P Yeargain
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day Dec
year 5 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug 22
1942 to 12 27 1942
that I last saw her alive on 12-22 1942
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Apoplexy

Due to _____

Due to Arterio Sclerosis

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

Major findings: _____
Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

23. Signature Jas W. Gouffmen (M. D. or other) _____
Address Brunswick St Date signed 12/27/42

RECEIVED

District Health Officer No. 4

District File Number 143-13-65

Date Filed 1-6-43

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..... *C. J. Hill*

Licensed Embalmer No. 1852

P. O. Address. Bismarck

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42272

Registration District No. 367

Primary Registration District No. 6246

Registrar's No.

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Rural
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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 _____

3. (a) PRINT FULL NAME Malisa J. Lashley

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

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

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

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

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ min.

9. Birthplace Indiana
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____, 19____;
that I last saw him _____ alive on _____, 19____;
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 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)

(b) 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

MOTHER FATHER

SUPPLEMENTARY 2

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