No. 2-43
-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 4570

Registration District No. 324 | Primary Registration District No. 3072 | Registrar's No. 6

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 20 North Odell
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community All her Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Saline 97
(c) City or town Marshall 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. 20 North Odell
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Perla Herfordt
3. (b) If veteran, name war #
3. (c) Social Security No. #
4. Sex 2
5. Color or race W
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 April (Month) 20 (Day) 1868 (Year)

8. AGE: Years 75 | Months 8 | Days 17 | If less than one day hr. min.
9. Birthplace Hannibal (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Martin VanBuren Williams
13. Birthplace Unknown (City, town, or county) 0 Unknown (State or foreign country)

MOTHER
14. Maiden name Nancy Gibson
15. Birthplace Unknown (City, town, or county) 0 Unknown (State or foreign country)

16. (a) Informant Theo Harris
(b) Address Marshall, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof I/10/1944 (Month) (Day) (Year)
(c) Place: burial or cremation Ridge Park Cemetery
18. (a) Signature of funeral director J. Leslie Summers
(b) Address Marshall Mo.
19. (a) 1-10-44 (Date received local registrar) (b) Miss T. O. Weatherford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7
year 44 hour 2 minute 30A M.
21. I hereby certify that I attended the deceased from 12-30-43, 19__, to 1-7, 19 44
that I last saw her alive on 1-6-44, 19__;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Pneumonia | 5 days |
| Due to Following Chest Cold | 3 days |
| 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)
(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 0

23. Signature L. C. Smith M.D (M. D. or other)
Address Marshall, Mo. Date signed 1-10-44

12 11 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 2-9-44

## 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 J. Leslie Sweeney

Licensed Embalmer No. 3235

P. O. Address Marshall, Texas

**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.**

, No. 2B
M—5-43
P I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

**1. PLACE OF DEATH:**
(a) County Saline
(b) City or town Marshall
(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 Life
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** Perla Herford

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 W

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

7. Birth date of deceased April (Month) 20 (Day) 1868 (Year)

8. **AGE:** Years 75 | Months 8 | Days | If less than one day: hr. ..... min.

9. Birthplace ..... (City, town, or county) No (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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) ..... (Registrar's signature)

## MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month January day .....
year 1944 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death ✓ | |
| Due to Pneumonia | 3 da |
| Due to Following Chest Cold | 3 da |
| Due to Lobar | |
| 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)
(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 ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY
108

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

4570