DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29158

Registration District No. 297 Primary Registration District No. 6021 Registrar's No. 11

1. PLACE OF DEATH:
(a) County Ray Co, Mo.
(b) City or town (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 Ray
(c) City or town Near Cowgill (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mary Jessiman
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Luther Jessiman
6. (c) Age of husband if alive 74 years
7. Birth date of deceased Aug (Month) 7 (Day) 1872 (Year)

8. AGE: Years 71 Months 0 Days 8 If less than one day hr. min.

9. Birthplace (City, town, or county) Germany (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

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

MOTHER
14. Maiden name Margaret Lange
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Luther Jessiman
(b) Address Cowgill Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Cowgill Mo.
18. (a) Signature of funeral director C A Baker
(b) Address Cowgill Mo
19. (a) Aug 17 1943 (Date received local registrar) (b) Mrs Chas W Shuppard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15
year 1943 hour 12 minute 30 M.
21. I hereby certify that I attended the deceased from Jan 12, 1941, to Aug 15, 1943
that I last saw her alive on Aug 14, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	2 yrs.
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)
(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 O C Kilbourn (M. D. or other) M.D.
Address Cowgill, Mo. Date signed 8/16/43

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
WRITING BLACK INK—MAKE A PERMANENT RECORD

9-13-43

SEP 24 1943

MAR 25 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. [redacted] working under my personal supervision.

Signed C M Reed

Licensed Embalmer No. 2194

P. O. Address Council Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
M—5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 44

Registration District No. 917 Primary Registration District No. 6021 Registrar's No.

1. PLACE OF DEATH:

(a) County Ray Co. Mo.

(b) City or town HARDIN 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 years, months or days)

In this community

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 Mary Jamison

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug. 7 (Month) (Day) 1862 (Year)

8. AGE: Years 71 | Months | Days | If less than one day min.

9. Birthplace (City, town, or county) (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 Aug. Day 7 year 1933 hour [illegible] minute 30 A. 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	
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

29158