

REC'D JUN 24 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

19380  
Do not use this space.

## 1. PLACE OF DEATH

(a) County St. Francois Registration District No. 775  
(b) Township Levy Primary Registration District No. 6020-A Registered No. 44  
(c) City Canne Terre (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. 6.571

## 2. PRINT FULL NAME

(a) Residence, No. Canne Terre Mo St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Shevare Horn

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 7, 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
78 1 11

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) St. Francois Co  
(STATE OR COUNTRY) Missouri

13. NAME William Ross Andrews

14. BIRTHPLACE (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

15. MAIDEN NAME Oliza Ann McHenry

16. BIRTHPLACE (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

17. INFORMANT Marta Horn  
(ADDRESS) Dealye Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Martin Chapel DATE May 20, 1938

19. FUNERAL DIRECTOR (NAME) Bernard Ind Co  
(ADDRESS) Canne Terre Mo

20. FILED May 20, 1938  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 18, 193822. I HEREBY CERTIFY, That I attended deceased from May-13-, 1938, to May-18-, 1938I last saw her alive on May-18-, 1938. Death is saidto have occurred on the date stated above, at 1.0 m.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Date of onset 5-13-38

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) R. L. Evans, M. D.(Address) Bonnetere Mo

**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,

*C. J. Claywell*

or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*C. J. Claywell*

Licensed Embalmer No.

*3706*

P. O. Address

*Bonne Terre 7*

**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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

19380.  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 770  
(b) Township Bonne Terre Primary Registration District No. 60.20.A Registered No. \_\_\_\_\_  
(c) City Bonne Terre (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Luella Jane Harn  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
78 1 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19.

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED May 20, 1938. N. W. Hankin  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 18, 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_. I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_. Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? If so, specify \_\_\_\_\_ (Signed) A. L. Emmons, M. D. (Address) Bonne Terre

SUPPLEMENTARY

REGISTERED AS PRESCRIBED BY LAW. REGISTRATION SHALL BE FREE FOR CERTIFICATES UNTIL THE

