

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.

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

36012

Do not use this space.

NOV 3 1938

1. PLACE OF DEATH

(a) County Jasper Registration District No. 4 16
 (b) Township _____ Primary Registration District No. 4948
 (c) City Sarcoxie (d) Street No. _____ 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.

2. PRINT FULL NAME

000 Lina Mae ~~May~~ May
 (a) Residence, No. Sarcoxie, Missouri St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. ~~Single, Married, Widowed, or Divorced~~ Widowed
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
~~Married to~~ (OR) WIFE OF Dick May

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 25, 1906

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	32	1	28	

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. <u>Housewife</u> 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation <u>many</u>	
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12. BIRTHPLACE (CITY OR TOWN) Rockville
 (STATE OR COUNTRY) Missouri

13. NAME Henry Wiley

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

15. MAIDEN NAME Zettie Parker

16. BIRTHPLACE (CITY OR TOWN) Rockville
 (STATE OR COUNTRY) Missouri

17. INFORMANT Zettie Wiley
 (ADDRESS) Sarcoxie, Missouri

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Sarcoxic cemetery DATE August 25, 1938

19. FUNERAL DIRECTOR (NAME) Alvin C. Cole
 (ADDRESS) Sarcoxie, Missouri

20. FILED Aug 24, 1938 Leroy
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 23, 1938

22. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1938, to Aug 23, 1938.
 I last saw her alive on Aug 22, 1938. Death is said to have occurred on the date stated above, at 12:30 PM.
 The principal cause of death and related causes of importance were as follows:

Leung abscess!

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? NO

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) [Signature], M. D.
 (Address) Sarcoxie, MISSOURI

11410

RECEIVED

District Health Officer No. 6,

District File Number 6-38-416

Date Filed 10/28/38

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,

GLEN C. CALE

or by

Registered Apprentice No. working under my personal supervision.

Signed Glen C. Cale

Licensed Embalmer No. 3708

P. O. Address S'ROXIE, MISSOURI

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

36012
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 416
(b) Township _____ Primary Registration District No. 4248 Registered No. _____
(c) City Sarcophic (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 Nina Mae May

(a) Residence, No. _____ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid
(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.
32 1 28

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)

13. NAME

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

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 _____ 19__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 23, 1928

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__ to _____, 19__

I last saw h. _____ 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:

Lung abscess

Date of onset

Other contributory causes of importance:

chr. bronchitis

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) N B Jack, M. D.

(Address) Sarcophic

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

