

REC'D NOV 23 1938

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

36239

Do not use this space.

1. PLACE OF DEATH *Madison* 2
(a) County *Madison* Registration District No. *539*
(b) Township *Marquand* Primary Registration District No. *4327* Registered No. *91*
(c) City *Marquand* (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 *Rhoda Sline Yow*
(a) Residence, No. *Marquand, Mo.* St. (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 (write the word) *widowed*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Apr - 5 - 1878*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 6 23
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *House Keeping*
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) *Richmond Ind*
13. NAME *David Hager*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Shelburn, Vt*
15. MAIDEN NAME *Wallace*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Cleveland O.*
17. INFORMANT *Kenneth Yow* (ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL PLACE *Cape Girardeau* DATE *Oct - 30 - 1938*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Horsman & Co Marquand Mo*
20. FILED *Oct 25 1938* *J. C. S. Laughlin* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 28 - 1938*
22. I HEREBY CERTIFY, That I attended deceased from *Oct. 28 - 1938*, to *Oct 28 - 1938*
I last saw h. u. alive on *dead 1938*, 1938. Death is said to have occurred on the date stated above, at *12:30 AM*
The principal cause of death and related causes of importance were as follows:
Angina Pectoris
Date of onset _____
Other contributory causes of importance: _____
Name of operation *none* 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? *no* 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) *M. B. Barber* M. D.
Fredericktown Mo (Address) _____

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.