

REC'D JAN 24 1939

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

43994  
Do not use this space.

1. PLACE OF DEATH  
(a) County Demarcat Registration District No. 651  
(b) Township Caruthersville Primary Registration District No. 4388 Registered No. 121  
(c) City Caruthersville (d) Street No. \_\_\_\_\_ St.  
(e) Length of residence in either town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.  
2. PRINT FULL NAME Lon Francis House  
(a) Residence, No. 129 St. 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 col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-5-1915  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.  
23 11 5  
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. work  
10. Date deceased last worked at this occupation (month and year) Oct 1938 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
13. NAME Charlie House  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
15. MAIDEN NAME Albie Moss  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Mary House Caruthersville Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE Morgan Ridge Center DATE 12/10/38  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. S. Smith Caruthersville Mo  
20. FILED Dec. 19, 1938 A. de Matin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-10-1938  
22. I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1938, to Dec. 10, 1938  
I last saw her alive on Nov. 12, 1938. Death is said to have occurred on the date stated above, at 9:30 P.M.  
The principal cause of death and related causes of importance were as follows:

Bilateral Pelvic -  
ovaries  
ovaries - V  
Date of onset ?  
Other contributory causes of importance: secondary anemia

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? STD 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? no  
If so, specify \_\_\_\_\_  
(Signed) Ad Shively, M. D.  
(Address) Hayti, Mo.

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.

13418

RECEIVED

District Health Officer No. 3,

District File Number 39-98

Date Filed 1-9-39

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 *W. C. Deane* .....

Licensed Embalmer No. 3941 .....

P. O. Address *Caruthersville* .....

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

43994  
Do not use this space.

1. PLACE OF DEATH

(a) County Demiseet Registration District No. 65-1  
(b) Township Caruthersville Primary Registration District No. 4388 Registered No. ....  
(c) City Caruthersville Street No. .... (If death occurred in Hospital or Institution, write its name instead of street and number) St. ....  
(d) 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 Frances House

(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 7 4. COLOR OR RACE cal 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (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.  
23 11 5-

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 Jan 10, 1939 Arthing Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-10-1938

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

I last saw h..... alive on ..... 19..... Death is said to have occurred on the ..... stated above, at ..... m.

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

Bilateral Salpingo-ovariitis  
probably hemorrhagic?  
(not proven)  
Date of onset 7-5  
The contributory causes of importance:  
secondary anemia

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) D. G. Shuren M. D.

(Address) Hayti Mo

SUPPLEMENT

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

