

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

44761  
 Do not use this space.

REC'D JAN 5 1938

1. PLACE OF DEATH

(a) County Union 2 Registration District No. 873  
 (b) Township Monticello 1 Primary Registration District No. 615  
 (c) City \_\_\_\_\_ (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 570 Louella Orlean  
 (a) Residence, No. Monticello Township 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 Widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 27 1859  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 4 8  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
 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) munsa, co mo  
 FATHER 13. NAME A. T. Minshall  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) San Luis Obispo  
 MOTHER 15. MAIDEN NAME Margie Ewing  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio  
 17. INFORMANT (ADDRESS) John Orlean Sheldon mo R 2  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Ohio Branch DATE Nov. 6 - 1938  
 19. FUNERAL DIRECTOR (ADDRESS) G. B. Bennett & Sons Sheldon Mo  
 20. FILED Nov 6 1938 W. H. Stokendoff Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 5 1938  
 22. I HEREBY CERTIFY, That I attended deceased from Nov 1 1938 to Nov 5 1938  
 I last saw him alive on Nov 1 1938 Death is said to have occurred on the date stated above, at 4 P m.  
 The principal cause of death and related causes of importance were as follows:  
Infectious Starches Oct 30 1938  
Acute suppurative parotitis Oct 30 1938  
Bronchopneumonia (terminal) 11/1/38  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes  
 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) C. E. Duckett, M. D.  
 (Address) Lamar, Mo.

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.

107 a  
Dm  
4/39

RECEIVED

District Health Officer No. 7,

District File Number 7-38-581

Date Filed 1-2-15-38

STATEMENT BY LICENSED EMBALMER

I, Carroll T. Beemy, Licensed Embalmer No. 2385

hereby certify that the body recorded on the reverse side of this certificate was embalmed by was not embalmed

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....

working under my personal supervision.

Signed Carroll T. Beemy

Licensed Embalmer No. 2385

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

44761  
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. ....  
(b) Township ..... Primary Registration District No. .... Registered No. ....  
(c) City ..... (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 Louieola Owens

(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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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.  
79 4 8

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19.....

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-5-1938

22. I HEREBY CERTIFY, That I attended deceased from

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:

Infection Diarrhea Date of onset  
Terminal Broncho  
Pneumonia 11/5/38  
Other contributory causes of importance:  
acute suppurative parotiditis  
no = nos mumps

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) C. G. Quessett, M. D.

(Address) Lamar, Mo

SUPPLEMENTARY

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.

