

DEC'D MAR 15 1939

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

6080

Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 109
(b) Township Cedar Primary Registration District No. 1718
(c) City NewBloomfield (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 Eva May Bennett Lynes

(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 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 T. J. Lynes

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12/23/1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
72 2 8

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) (STATE OR COUNTRY) Missouri

13. NAME John N. Bennett

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

15. MAIDEN NAME Elvira Moore

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

17. INFORMANT T. J. Lynes (ADDRESS) NewBloomfield, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE NewBloomfield, DATE 3/2/1939, 19__

19. FUNERAL DIRECTOR (NAME) Ray A. Holt (ADDRESS) NewBloomfield, Missouri

20. FILED Mar 10, 1939 Quelshak Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/1/1939, 19__

22. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1939 to Mar 1, 1939
I last saw her alive on Mar 1, 1939. Death is said to have occurred on the date stated above, at 7 Am.
The principal cause of death and related causes of importance were as follows:

Acute Nephritis

Date of onset

Feb 24
1939

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? Urea 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) Quelshak, M. D.

(Address) New Bloomfield, Mo

130

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
DIVISION OF PROFESSIONAL REGULATION

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.

UAC

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

6080
Do not use this space.

1. PLACE OF DEATH
(a) County Callaway Registration District No. 109
(b) Township Cedar Primary Registration District No. 3158 Registered No. 664
(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 Eva May Bennett Hyatt
(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 <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>72</u>	MONTHS <u>2</u>	DAYS <u>8</u>	If LESS than 1 day, hrs. or min.
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..... 19..... Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR)	<u>3-1-1939</u>
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: <u>acute nephritis</u> <u>121</u> Date of onset	
Other contributory causes of importance: <u>Chronic Nephritis</u>	
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) <u>E. M. Reas</u> , M. D. (Address) <u>New Bloomfield Mo</u>	

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTAL

