

1939 MAR 23 1939

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

6213
Do not use this space.

1. PLACE OF DEATH

(a) County Chautauq Registration District No. 175
 (b) Township Salisbury Primary Registration District No. 5243 Registered No. 10
 (c) City Salisbury (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred 30 mos. ds. 6 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Revernia L Mott
 (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

MEDICAL CERTIFICATE OF DEATH

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 James F Mott
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 20 1857
 7. AGE YEARS 81 MONTHS 4 DAYS 29 If LESS than 4 day, _____ hrs. or _____ min.
 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 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 1 1939
 22. I HEREBY CERTIFY, That I attended deceased from Feb 3 1939 to March 1 1939
 I last saw her alive on 3-1-39, 1939. Death is said to have occurred on the date stated above, at 10 a.m.
 The principal cause of death and related causes of importance were as follows:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
 13. NAME Todd
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 17. INFORMANT Frank Mott (ADDRESS) Salisbury Mo

Chorea Myocarditis
 Date of onset _____
 Other contributory causes of importance: Fatigued Hip!

18. BURIAL, CREMATION, OR REMOVAL PLACE Salisbury DATE 3/2 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dr. B. W. ...
 20. FILED 3/1 1939 Local Registrar.

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) Dr. ... M. D.
 (Address) Salisbury Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

144B

THE STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

RECEIVED
District Health Officer No. 8,
District File Number
3/21/39
Date Filed

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, *J. H. [Signature]*

Licensed Embalmer No. *3981*

P. O. Address *Salisbury, Ma*

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

6213
Do not use this space.

1. PLACE OF DEATH
 (a) County Chariton Registration District No. 175
 (b) Township Salisbury Primary Registration District No. 6243
 (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 Slovenia L. Matt
 (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 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.
	<u>81</u>	<u>4</u>	<u>29</u>	

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) 3-1, 1959

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:
Chronic Myo Carditis Date of onset ..
Fractured Hip
 Other contributory causes of importance:

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 accident Date of injury 3/3, 1959
 Where did injury occur? Stumbled + fell in yard at home
 (Specify city of town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury at home
stumbled + fell
 Nature of injury front left hip, neck, femur

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify G. M. Hawkins, M. D.
 (Signed) Salisbury Mo
 (Address)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

