

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

7564
 Do not use this space.

REC'D MAR 21 1939

1. PLACE OF DEATH

(a) County Ralls Registration District No. 726
 (b) Township Spencer Primary Registration District No. 4432 Registered No. _____
 or City NEW LONDON (d) Street No. New London, Mo. _____ 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 Martha E. Jones

(a) Residence, No. New London, Mo. 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 Kenneth
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 20 1911
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
27 10 12
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 1 1939
 22. I HEREBY CERTIFY, That I attended deceased from Jan 30 1939 to Feb 1 1939
 I last saw her alive on Feb 1 1939 Death is said to have occurred on the date stated above, at 3 P.
 The principal cause of death and related causes of importance were as follows:

Eclampsia

Date of onset

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) MARKFORD (STATE OR COUNTRY) MO.

FATHER 13. NAME William Stoltz

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

MOTHER 15. MAIDEN NAME Sarah Lambertson

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

17. INFORMANT Kenneth Jones (ADDRESS) New London, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE MARKFORD MO DATE Feb. 2 1939

19. FUNERAL DIRECTOR (NAME) James O. Lane (ADDRESS) Kangitah, Mo.

20. FILED 2/5 1939 Blanche Megown Local Registrar

Name of operation _____ 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? _____ 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) H. J. Waters M. D.
 _____ (Address) New London, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. How amount of status EXACTLY. PHYSICIANS should state

146

RECEIVED

District Health Officer No. 10

District File Number 10-39-408

Date Filed MAR 10 1939

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 Myself

....., Registered Apprentice No.....
working under my personal supervision.

Signed Michael J. Adamec

Licensed Embalmer No. 3246

P. O. Address Hannibal - MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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

75-64
Do not use this space.

1. PLACE OF DEATH

(a) County Ralls Registration District No. 726
(b) Township New London Primary Registration District No. 4437 Registered No. _____
(c) City New London (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

Martha E. Jones
(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 1 - 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
27 10 12

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

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

Eclampsia
General Convulsions

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:
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FATHER
13. NAME

Name of operation _____ Date of _____

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

What test confirmed diagnosis? _____ Was there an autopsy? _____

MOTHER
15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

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

Where did injury occur? _____ (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19____

Manner of injury _____ Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____

20. FILED _____, 19____ Local Registrar.

If so, specify _____ (Signed) W. J. Watson, M. D.

(Address) New London Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. PROPERTY ASSURED. EXACT STATEMENTS HOW ENVA MOORE important.

