

REC'D APR 21 1939

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

11140
Do not use this space.

1. PLACE OF DEATH
(a) County Gasper Registration District No. 411
(b) Township Garton Primary Registration District No. 2002 Registered No. _____
(c) City _____ (d) Street No. 205 Va. _____ 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 Flavia Church
(a) Residence, No. 205 Va. Ave 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 W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 19, 1890
7. AGE YEARS MONTHS DAYS 49 1 16
8. TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SAWYER, BOOKKEEPER, ETC. Nurse work.
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) West Sulphur Spgs Ark.
13. NAME Thomas B. Lindsey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
15. NAME Mary M. D. Pritchard
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Lucy Lindsey
18. SIGNATURE, CREATION, OR REMOVAL Butter Creek Cem. DATE 3-9-39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. B. Chapman
20. FILED 3-10-39 202 392
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-7-39
22. I HEREBY CERTIFY, That I attended deceased from March 6, 1939, to March 7, 1939
I last saw her alive on March 7, 1939 Death is said to have occurred on the date stated above, at 9-15 AM.
The principal cause of death and related causes of importance were as follows:

Influenza
(Hemorrhagic type)

Date of onset _____

Other contributory causes of importance: HB

Name of operation None Date of _____
What test confirmed diagnosis? Funeral 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) W. B. Chapman M. D.
(Address) Garton, 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.

I-X15605

RECEIVED

District Health Officer No. 6,

District File Number 6-39-838

Date Filed APR 12 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.....
....., 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.