

REC'D MAY 18 1939

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

14606
Do not use this space.

1. PLACE OF DEATH

(a) County Clay Registration District No. 148
 (b) Township Fishing Creek Primary Registration District No. 3011
 (c) City Excelsior Springs (d) Street No. Mitchell Blinn Registered No. 62
 (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 Elizabeth Hutchinson

(a) Residence, No. _____ St. Corning, Iowa
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 18/66
 7. AGE YEARS 73 MONTHS 8 DAYS _____ If LESS than day, _____ hrs. or _____ min.
 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) Iowa
 13. NAME Caldevell
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont know
 15. MAIDEN NAME Dont know
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont know

17. INFORMANT (ADDRESS) H. F. Bisher
Corning, Iowa

18. BURIAL, CREMATION, OR REMOVAL PLACE Corning, Ia. DATE 4-29-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. Lande Richard
Excelsior Springs, Mo.

20. FILED May 1, 1939 Kurfer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-29 1939
 22. I HEREBY CERTIFY, That I attended deceased from 4-21, 1939, to 4-29, 1939.
 I last saw her alive on 4-29, 1939. Death is said to have occurred on the date stated above, at 3:50 P.M.
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage
Hypertension with arteriosclerosis
Blood Pressure 208-120
 Other contributory causes of importance: _____
 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? no
 If so, specify _____
 (Signed) [Signature]
 (Address) Excelsior Springs, 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.

STATEMENT OF QUALITY OF EMBALMING
RETURNED TO THE
STATE OF CALIFORNIA

DATE OF DEATH

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

STATE OF CALIFORNIA, COUNTY OF _____, DISTRICT HEALTH OFFICER NO. 8, DISTRICT FILE NUMBER _____, DATE FILED _____



RECEIVED
District Health Officer No. 8,
District File Number _____
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,

Claude Richard

or by _____

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

Signed *Claude Richard*

Licensed Embalmer No. *2701*

P. O. Address *Excelsior Springs, Mo.*

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.