

REC'D JUN 21 1939

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

18501  
Do not use this space.

1. PLACE OF DEATH

(a) County Dent Registration District No. 266  
(b) Township \_\_\_\_\_ Primary Registration District No. 9164 Registered No. 40  
(c) City Salem (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 520 Mrs Fannie Mounce

(a) Residence, No. \_\_\_\_\_ St.  (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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 20, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
80 1 21

OCCUPATION 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) Ind.

FATHER 13. NAME XXXXXXXX

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

MOTHER 15. MAIDEN NAME XXXXX

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) XXX  
XX

17. INFORMANT Joe Mounce (ADDRESS) Salem Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Stagner DATE 5/13/39

19. FUNERAL DIRECTOR J. C. K. Spencer (ADDRESS) Salem Mo

20. FILED May 13 1939 F. Keith MD Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 11 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 13 1939 to May 10 1939  
I last saw h. ev alive on May 10 1939 Death is said to have occurred on the date stated above, at 5:30 P.M.

The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditis Date of onset 1939

Other contributory causes of importance:  
Chronic Hepatitis 1936

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis renal sign Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? no 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 none  
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify Chronic Nephritis M. D. \_\_\_\_\_  
(Signed) Salem Mo (Address) Salem Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

MARON RESERVED FOR BINDING

V. S. 10-2  
50M-7-20-37  
I X12004

*Bill*

STATEMENT BY LICENSED EMBALMER

I, Wm. W. McDonald, Licensed Embalmer No. 3806

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Wm. W. McDonald

Licensed Embalmer No. 3806

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.)