

REC'D AUG 12 1939

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

25514
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin
(b) Township Arlewin
(c) City Arlewin

Registration District No. 286
Primary Registration District No. 4170

Registered No. _____

(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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 10 1910

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 6M 2 23

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) Jackson (STATE OR COUNTRY) Missouri

FATHER 13. NAME Jacob Doyle

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

MOTHER 15. MAIDEN NAME Elizabeth Martin

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

17. INFORMANT B. F. Seabaugh (ADDRESS) Homer'sville, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Apph Creek DATE 8/4 1939

19. FUNERAL DIRECTOR (NAME) Paul Salmon (ADDRESS) Ferret, Mo

20. FILED _____ 19 _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Aug 1 1939 to Aug 2 1939

I last saw h. _____ alive on Aug 2 1939 Death is said to have occurred on the date stated above, at 7:10 P.M.

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

Malignant Abdominal wall tumor probably present prior to ovary excision
Other contributory causes of importance: _____

Date of onset _____

Name of operation none 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) B. F. Seabaugh M. D.
Homer'sville
259 (Address)

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.

MO-7-10-19-1 X10603

RECEIVED

District Health Officer No. 3,

District File Number 839-496

Date Filed 8-19-39

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

255-14

Do not use this space.

1. PLACE OF DEATH

(a) County Dunklin Registration District No. 286
 (b) Township Holcomb Primary Registration District No. 4176 Registered No.
 (c) City Holcomb (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 Alma C. Margrave

(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 D. M. Margrave

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 10 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 2 23

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) Jackson
 (STATE OR COUNTRY)

FATHER 13. NAME Jacob Doyle

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

MOTHER 15. MAIDEN NAME Elizabeth Martin

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

17. INFORMANT B. J. Stoughton
 (ADDRESS) Hornersville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Apple Green DATE 8/4

19. FUNERAL DIRECTOR Paul Salasoa
 (ADDRESS) Remondt Mo

20. FILED Sept 2 19 37 H. Anderson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Oct 1 1938 to Aug 2 1939
 I last saw h. alive on Aug 2 1939. Death is said to have occurred on the date stated above, at 7:15 m.
 The principal cause of death and related causes of importance were as follows:

Malignant Abdominal tumor
probably Carcinoma
R. Ovary + Adnexa

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? 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 C. G. Cope, M. D.
 (Signed) Hornersville Mo
 (Address) 2010

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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5-25514 1939