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.

AUG 12 1939

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

26952
Do not use this space.

1. PLACE OF DEATH
(a) County Saline — Registration District No. 799
(b) Township — Primary Registration District No. 4479 — Registered No. 33
(c) or City Slater, Missouri. — (d) Street No. 125 Broadway. 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 Catherine Virginia Birch. 620
(a) Residence, No. 125 Broadway. 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): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Frank Birch
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March-25-1880
7. AGE: YEARS 59 — MONTHS 3 — DAYS 16 — If LESS than 1 day, ...hrs. or ....min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Near Slater Saline Co Mo.

FATHER
13. NAME: Oscar Crane
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cincinnati, Ohio.

MOTHER
15. MAIDEN NAME: Sophia Cobb
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Murfreesborro Tennessee.

17. INFORMANT (ADDRESS): Frank Birch, Slater, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Slater City — DATE: July-13-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Jones & Salzer, Slater Mo. 709

20. FILED July 12 1939 W. M. Tuttle
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): July-11-39, 19

22. I HEREBY CERTIFY, That I attended deceased from 1936, 19, to July-11-1939
I last saw her alive on July-10-1939. Death is said to have occurred on the date stated above, at 3.10 m. AM
The principal cause of death and related causes of importance were as follows:

Polyneuritis. — Date of onset

87a

Other contributory causes of importance:

Tic-douloureux.

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
(Signed) M. C. Duggins, M. D.
(Address) Slater Mo.

(Licensed Embalmer's Statement on Reverse Side)

CEIVED
trict Health Officer No. 8,
rict File Number 8/9/39
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, or by ..... Registered Apprentice No. ..... working under my personal supervision.

Signed .....

Licensed Embalmer No. 3/43

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.