

REC'D SEP 14 1939

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

28440
Do not use this space.

1. PLACE OF DEATH **Adair**

(a) County..... Registration District No. **4**

(b) Township..... **Kirkville** Primary Registration District No. **3001** Registered No.....

(c) City..... (d) Street No. **Stickler Hospital** 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **Zella M. Transano**

(a) Residence, No. **Novinger Mo.** 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 **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **divorced**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **J. B. Transano**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 3 - 1904**

7. AGE YEARS **35** MONTHS **6** DAYS **5** IF LESS than 1 day,hrs. ormin.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **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) **9-2-1939** 11. Total time (years) spent in this occupation **15 yr.**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Albia Iowa**

FATHER 13. NAME **Walter Clifton**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **un-known**

MOTHER 15. MAIDEN NAME **Nancy Smith**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **un-known**

17. INFORMANT **J. B. Transano** (ADDRESS) **Novinger Mo.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Novinger Cemt.** DATE **Sept. 8, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Dee Riley Kirkville Mo.**

20. FILED **Sept. 12, 1939** **Spencer C. Freeman** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 6, 1939**

22. I HEREBY CERTIFY That I attended deceased from **Sept. 5, 1939** to **Sept. 6, 1939**

I last saw her alive on **Sept. 6, 1939** Death is said to have occurred on the date stated above, at **1:15 p. m.**

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

Shock - Toxicemia following operation for Bowel obstruction

Date of onset _____

Other contributory causes of importance:

Name of operation _____ Date of **9-6-39**

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? _____

If so, specify **At Stickler** (Signed) **Stickler**, M. D.

(Address) **Kirkville 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.

1226

RECEIVED

District Health Officer No. 10

District File Number 4-39-1591

Date Filed SEP 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 conform with the above constitutes grounds for revocation of license.)

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

OFFICE OF THE DISTRICT HEALTH OFFICER

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28440
Do not use this space.

1. PLACE OF DEATH
 (a) County Adair Registration District No. 4
 (b) Township _____ Primary Registration District No. 3001 Registered No. _____
 (c) City Kirksville (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 Zella M. Trancano
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (writes the word) Div

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
35- 6 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Oct 1 1939 Spencer L. Dreamer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 6 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____ 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Shocks - Toxemia following operation
Small Obstruction
 Other contributory causes of importance:
due to adhesions resulting from previous operation - 1 year ago.

Name of operation _____ Date of _____
 What test confirmed diagnosis? 1226 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) R. O. Stickler M. D.
 (Address) Kirksville Mo.

SUPPLEMENT

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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.

