

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

30413  
Do not use this space.

REC'D SEP 8 1939

**1. PLACE OF DEATH**

(a) County Jacobs Registration District No. 859  
 (b) Township Oliver Primary Registration District No. 6130  
 (c) City Kirbyville Mo. 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. How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. 160 Emma Jane Aubery 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**

**MEDICAL CERTIFICATE OF DEATH**

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 JOE Aubery  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 16-1863  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
75- 9 13

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 28, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from June 15, 1939, to Aug 28, 1939  
 I last saw h. as alive on Aug 28, 1939. Death is said to have occurred on the date stated above, at 9 A. M.  
 The principal cause of death and related causes of importance were as follows:

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. Hotel  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

Other contributory causes of importance:  
Cancer of lower stomach and upper small intestine  
 Date of onset 3 years ago

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

13. NAME Samuel Burns

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

15. MAIDEN NAME Jane Farris

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

17. INFORMANT (ADDRESS) Sam Aubery Kirbyville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Road Cntry 8/29 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wheeler Branson Mo

20. FILED 8/28 39 John H. Baxter Local Registrar

Name of operation none 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) Dr. P. C. Helmer  
 \_\_\_\_\_ (Address) Branson Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Information showing no ceremony supplied. AGE should be stated. EXACT STATEMENT OF OCCUPATION is very important.

RECEIVED

District Health Officer No. 6.

District File No. 939-1749

Date Filed SEP 5 1939

508

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**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 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.

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1. PLACE OF DEATH

(a) County Janey Registration District No. 859  
(b) Township Olney Primary Registration District No. 6130 Registered No. 32  
(c) City..... (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

Emma Jane Aubrey  
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m  
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-28, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from

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

19... to ... 19...  
I last saw h... alive on ... 19... Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
75 9 12

to have occurred on the date stated above, at... m.  
The principal cause of death and related causes of importance were as follows:

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

Date of onset

Carcinoma of lower stomach & liver  
with all intestine  
carcinoma existed primarily in duodenum and stomach  
Other contributory causes of importance:  
Chro. nephritis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation 46 Date of.....

13. NAME

What test confirmed diagnosis?..... Was there an autopsy?.....

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

23. If death was due to external causes (violence), fill in also the following:

15. MAIDEN NAME

Accident, suicide, or homicide?..... Date of injury.....

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

Where did injury occur?..... (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

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

Manner of injury.....

19. FUNERAL DIRECTOR (ADDRESS)

Nature of injury.....

20. FILED 19...

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify (Signed) E. E. Gultner, M. D.  
(Address) Branson, Mo.

SUPPLEMENT

Local Registrar.

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

S-30413