

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.

 DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS 1939

 MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32480

State File No.

Registration District No.

347

Primary Registration District No.

3018

Registrar's No.

1. PLACE OF DEATH:

 (a) County Henry
 (b) City or town Clinton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community 14 years, months or days (Specify whether)
3. (a) PRINT FULL NAME Susie-Isabel-Canada

3. (b) If veteran, name war. 3. (c) Social Security No.

 4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Edad Canada 6. (c) Age of husband or wife if alive 28 years (Day) (Year)
 7. Birth date of deceased Jan 28 1868 (Month) (Day) (Year)

 8. AGE: Years 70 Months 7 Days 4 If less than one day hr. min.
9. Birthplace Kansas (City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business

12. Name David Harrison13. Birthplace Louisville Kentucky (City, town, or county) (State or foreign country)14. Maiden name Lucy Qualen15. Birthplace Kentucky (City, town, or county) (State or foreign country)16. (a) Informant's own signature Lucie Canada(b) Address 828 N. Winchester Ave17. (a) Hunkar (b) Date thereof 9 3 39 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Frank W. W. W.(b) Address Clinton19. (a) 9-23 (b) 39 Dr. J. R. Hunkar (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

 (a) State Missouri (b) County Henry
 (c) City or town Clinton (If outside city or town limits, write "RURAL")
 (d) Street No. 515 6th Lincoln (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

 20. DATE OF DEATH: Month 9 day 2 year 1939 hour 8 minute 00 P. M.

 21. I hereby certify that I attended the deceased from Sept 1, 1939, to Sept 2, 1939; that I last saw her alive on Sept 2, 1939; and that death occurred on the date and hour stated above.

 Immediate cause of death Cerebral thrombosis Duration 2 days
 Due to 8 2 39

Due to

Other conditions (Include pregnancy within 3 months of death)

 Major findings: Of operations no
Of autopsy none

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature S. B. Hughes (M. D. no)Address Clinton Date signed 9/2/39

RECEIVED
District Health Officer No. 7,
District File Number 7-39-1377
Date Filed 10-7-39

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

Fred W. Whiskey

Licensed Embalmer No. _____

Clinton M.

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.