53
2
1

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.

50M-9-19-38 I X16605

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

DEC'D OCT 1 ? 1939

32772
Do not use this space.

1. PLACE OF DEATH
(a) County LACLEDE
(b) Township
(c) or City LEBANON
Registration District No. 449
Primary Registration District No. 4267 Registered No.
(d) Street No. WALLACE HOSPITAS 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 200 IDA E. Rich
(a) Residence, No. TAYLOR AVE 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 (write the word) MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF O. A. Rich
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) FEB 4-1874
7. AGE YEARS 65 MONTHS 7 DAYS 24 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) LACLEDE Co Mo 0

FATHER
13. NAME AMOS KNIGHT 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) VERMONT 1

MOTHER
15. MAIDEN NAME JOSEPHINE CLATON
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) VA

17. INFORMANT (ADDRESS) O. A. Rich LEBANON, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE LEBANON Mo. DATE Oct 1, 39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) PALMER'S LEBANON Mo
20. FILED 9-30 1939 J. A. McCaub Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) SEPT. 28, 1939
22. I HEREBY CERTIFY, That I attended deceased from 9/21, 1939, to 9-28, 1939
I last saw her alive on 9/28, 1939 Death is said to have occurred on the date stated above, at 6:50 A.m.
The principal cause of death and related causes of importance were as follows:
Embolism (Coronary) Date of onset
94
Other contributory causes of importance:
Hysterectomy
Large fibroid removed
6 days prior to death.
Name of operation Hysterectomy Date of 9/21/39
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? No
If so, specify
(Signed) J. Bummer M. D.
(Address) Lebanon Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 7-39-1393
Date Filed 10-9-39

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 R. A. Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon Me.

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.