

OCT 19 1939

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

33237  
Do not use this space.

1. PLACE OF DEATH *Phelps.*

(a) County *Phelps.* Registration District No. *678*

(b) Township *ST JAMES.* Primary Registration District No. *5904*

(c) City ..... (d) Street No. .... St.

(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 *MARY BLAIR*

(a) Residence, No. *ST JAMES MO* St.  (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 *Mrs. Mary Blair*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *FEBY - 12 - 1879*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

*60 7 10*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housewife*

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) *FRANCE*

13. NAME *Lowie Delaby.*

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

15. MAIDEN NAME *MARY DEWAM.*

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

17. INFORMANT (ADDRESS) *Mrs. Mary H. Blair*

18. BURIAL, CREMATION, OR REMOVAL PLACE *STANTON* DATE *9-25-39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *John ...*

20. FILED *9-25-39* *Blair* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9-25-1939*

22. I HEREBY CERTIFY, That I attended deceased from *July 8/ 1939*, to *September 23, 1939*

Last saw him alive on *September 23, 1939*. Death is said to have occurred on the date stated above, at *12:20 p.m.*

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

*Carcinoma of sigmoid rectum*

*H<sup>1</sup>*

Other contributory causes of importance: *cholelithiasis 1936*

Name of operation *Tumour* Date of *...*

What test confirmed diagnosis? *Tumour* 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 *C. V. Hammler, M. D.*

(Signed) *Ed. James, M.D.* (Address) *...*

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.

WHILE EARLY, WITH ONFADING IMPRESSIONS IS A PERMANENT RECORD

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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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 1039290

Licensed Embalmer No.....

Date Filed 10/10/39

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.**