

OCT 10 1939

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

33665
Do not use this space.

1. PLACE OF DEATH *2*
 (a) County *Spencer* Registration District No. *824*
 (b) Township *Amosa* Primary Registration District No. *6894* Registered No. _____
 (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 *623 Mary Catherine Straight*
 (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

3. SEX *♀* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec-3-1860*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>78</i>	<i>9</i>	<i>19</i>	

OCCUPATION

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

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) *Scotland County Mo*

FATHER

13. NAME *William Straight* *0*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *West Virginia* *1*

MOTHER

15. MAIDEN NAME *Mary Knorr* *1*

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

17. INFORMANT (ADDRESS) *Walter Straight Amosa Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Amosa Mo* DATE *9-22-1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Cray Knorr Van Buren Mo*

20. FILED *9-21-1939* *Frank Hyde MD* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY that I attended deceased from *May-1-1939* to *Sept 21-1939*
 I last saw him alive on *August-1-1939*. Death is said to have occurred on the date stated above, at *11 P. m.*
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
§ 20

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) *Frank Hyde* M. D.
 (Address) *Amosa 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.

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.....

RECEIVED
working under my personal supervision.

District Health Officer No. 5,

District File Number. 1039 326

Date Filed 10/18/39

Signed.....

Licensed Embalmer No.....

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.