

D.B. 36819
State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 651

Primary Registration District No. 4388

Registrar's No. 100

1. PLACE OF DEATH: 2

(a) County Pennicott

(b) City or town Cauthersville

(c) Name of hospital or institution: Ant
Little Grace
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 20 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County Pennicott

(c) City or town Cauthersville
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Mary Ellen Eltridge

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 8th
year 39 hour 10 minute 15 A. M.

21. I hereby certify that I attended the deceased from Oct. 5 - 1939, to Oct. 8 - 1939;
that I last saw her alive on Oct. 8 - 1939
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
divorced widowed

7. Birth date of deceased: 2 28 1869
(Month) (Day) (Year)

Immediate cause of death Lobar Pneumonia Duration 5 days

(Primary)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>7</u>	<u>10</u>	hr. min.

9. Birthplace Ala
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name John Campbell

13. Birthplace D. K.
(City, town, or county) (State or foreign country)

14. Maiden name D. K.

15. Birthplace D. K.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Willard Eltridge

(b) Address Cauthersville Mo

17. (a) Burial (b) Date thereof 10-9-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cover

18. (a) Signature of funeral director H. S. Smith

(b) Address Cauthersville Mo

19. (a) Oct. 14, 1939 (b) Cida Martin
(Date received local registrar) (Registrar's signature)

Major findings: _____

Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) _____

(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?
_____ (Specify type of place)

While at work? _____ Means of injury _____

23. Signature J. R. Union (M. D. or other) _____

Address Cauthersville, Mo Date signed 10-14-39

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

RECEIVED

District Health Officer No. 3,

District File Number 1139-64

Date Filed 11/7/39

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.....

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.