

1940

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

44168  
Do not use this space.

1. PLACE OF DEATH

(a) County Hodaway Registration District No. 626  
 (b) Township 1 Primary Registration District No. 303 Registered No. 160  
 (c) City Maryville (d) Street No. 52 Frances Hospital 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. or of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME SARAL MARGARET ELIZABETH McNEESE

(a) Residence, No. Stanberry Mo 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 Female 4. COLOR OR RACE whit 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert McNeese  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-21-1886  
 7. AGE YEARS 53 MONTHS 2 DAYS 13 If LESS than 1 day, .....hrs. or .....min.  
 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) 9-1-1939 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Marietta (STATE OR COUNTRY) West Virginia

13. NAME Thedore J. B. Spangler 9

14. BIRTHPLACE (CITY OR TOWN) Don't know 9 (STATE OR COUNTRY)

15. MAIDEN NAME Elizabeth B. Fox 9

16. BIRTHPLACE (CITY OR TOWN) Don't know 9 (STATE OR COUNTRY)

17. INFORMANT Johnny McNeese (ADDRESS) Stanberry Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Muller Cemetery DATE 12-5 1939

19. FUNERAL DIRECTOR (NAME) Wm. Johnson (ADDRESS) Stanberry Mo.

20. FILED 12-4 1939 Mamie E. Clardy Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-4 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 11-30 1939, to 12-4 1939  
 I last saw her... alive on 12-3 1939. Death is said to have occurred on the date stated above, at 1 a.m.  
 The principal cause of death and other causes of importance were as follows:

Streptococcus Septicemia  
 Date of onset 11-24-39

Other contributory causes of importance:

Name of operation none Date of.....  
 What test confirmed diagnosis? General Was there an autopsy?.....  
labour

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 None  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify.....

(Signed) J. M. Boyles M. D.  
 (Address) Conception, Ind.

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.

FORM 1-12-38 I X14023

36

RECEIVED

District Health Officer No. 11,

District File No. \_\_\_\_\_

40-1954

Date Filed Jan 13 1940

RECORDS SECTION

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, \_\_\_\_\_

*J. Evan Johnson*

\_\_\_\_\_, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed *J. Evan Johnson*

Licensed Embalmer No. 3492

P. O. Address *Stanberry Mrs*

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

44168  
Do not use this space.

1. PLACE OF DEATH

(a) County nodaway Registration District No. 625-  
(b) Township..... Primary Registration District No. 3031 Registered No.....  
(c) City marionville (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

Sarah Margaret Elizabeth McNeese  
(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 \_\_\_\_\_ 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) \_\_\_\_\_

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
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) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_ 14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_ 16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19.

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) \_\_\_\_\_, 19 \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19 \_\_\_\_\_, to \_\_\_\_\_, 19 \_\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

Streptococcus Septicemia  
Probably from ulceration on left leg  
Date of onset \_\_\_\_\_

Other contributory causes of importance: 157 12

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 \_\_\_\_\_ M. D.  
(Signed) J. M. Boyles  
(Address) Concepts of Medicine

SUPPLEMENT

N. B.—Every item of information should be carefully supplied. AGE should be stated. PEACTY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY

Local Registrar.

