

Registration District No. 703

Primary Registration District No. 4424

Registrar's No. _____

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.

1. PLACE OF DEATH:
 (a) County Polk 2
 (b) City or town Humansville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months & days 3 0 0

3. (a) PRINT FULL NAME ANNA L. MEAD
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race White
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Chas. Mead 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 16 1897
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 2 25 hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business 0

MOTHER FATHER { 12. Name Tom Miller 0

13. Birthplace _____
 (City, town, or county) (State or foreign country) MO

14. Maiden name Bessie Bond

15. Birthplace _____
 (City, town, or county) (State or foreign country) MO

16. (a) Informant's own signature Charles Mead

(b) Address Humansville Mo

17. (a) Burial (b) Date thereof Dec. 13-1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Humansville Cemetery

18. (a) Signature of funeral director Joseph L. Timstone While at work _____ (Specify type of place)
 (b) Address Humansville Mo (e) Means of injury _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Polk
 (c) City or town Humansville
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12
 year 1939 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct
 _____, 1939, to Dec 12, 1939;
 that I last saw him alive on Dec 11-39, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration 1 1/2 yrs

Due to _____

Due to 72

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

Major findings: Of operations none

Of autopsy none

PHYSICIAN

 Underline the cause to which death should be charged statistically

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? _____

(e) _____ (Specify type of place) (e) Means of injury _____

23. Signature Ressie C. News (M. D. or other) !

Address Humansville Mo Date signed 12-22-39

RECEIVED

Health Officer No. 7,
District File Number 1-40-101
Date Filed 1-9-40

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 *Ralph A. Joseph*
Licensed Embalmer No. *3149*
P. O. Address *Huntsville*

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

44354
Do not use this space.

1. PLACE OF DEATH *Palau*
 (a) County *Palau* Registration District No. *703*
 (b) Township Primary Registration District No. *442.4* Registered No. _____
 (c) City *Humansville* (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 *Anna R. Mead*
 (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 *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *m*

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.
42 2 25

OCCUPATION

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 *Dec 20* 19*39* *Ora M. Renda*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 12*, 19*39*

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:

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 *R.C. Neuronal*, M. D.
 (Signed) _____ (Address) *Humansville Mo*

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

