No. 2
-11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1982

State File No.

FILED FEB 15 1940

Registration District No. 156

Primary Registration District No. 4090

Registrar's No. 5

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

980

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Harrisonville Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Harrisonville Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community 50 years 1-25

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass

(c) City or town Rural, RFD #2
(If outside city or town limits, write "RURAL")

(d) Street No. 5 Miles N.W. of Harrisonville
(If rural, give location)

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

3. (a) PRINT FULL NAME Francis D. Martindale

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Fe

5. Color or race wh

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Joseph Martindale

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased 6 (Month) 29 (Day) 1856 (Year)

8. AGE: Years 83 Months 73 Days 7 If less than one day ____ hr. ____ min.

9. Birthplace Johnson Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ____

FATHER
12. Name Joseph Thompson
13. Birthplace Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Katherine De Masters
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant L. W. Thompson

(b) Address Butler RFD #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-40 (Month) (Day) (Year)

(c) Place: burial or cremation Brown Cem.

18. (a) Signature of funeral director Atkinson Bros

(b) Address Harrisonville Mo 845

19. (a) 1/29/40 (Date received local registrar) (b) Jeduskey M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28 year 1940 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1-25-1940, to 1-28-1940; that I last saw her alive on 1-28-1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Senile Debility

Due to Exposure & malnutrition

Other conditions (Include pregnancy within 3 months of death) 8 2 W

Major findings:
Of operations ____
Of autopsy ____

Duration

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature David Stang (M. D. or other)

Address Harrisonville Mo Date signed 1/29

(Licensed Embalmer's Statement on Reverse Side)

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.