

No. 2
-11-10-39
5-17-39
I X21572

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1987

State File No. _____

FEB 15 1940

Registration District No. 162

Primary Registration District No. 52274564

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Peculiar, Mo
(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 or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cass

(c) City or town Peculiar
(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 Martha Isabel Bishop

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9
year 1940 hour _____ minute 11:00 M.

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Charles C. Bishop

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased April 18 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 15,
_____ 1939, to January 9 _____ 1940

that I last saw her alive on January 9 _____ 1940
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

69 8 21 hr. _____ min. 0

Immediate cause of death Wernicke's encephalopathy (Edema Brain)

Duration 2 days

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

Due to Chronic Encephalopathy?

10. Usual occupation Housewife

Due to Chronic Myocarditis?

11. Industry or business _____

Other conditions Hypertension
(Include pregnancy within 5 months of death)

MOTHER FATHER { 12. Name Robert S. Burrey

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

14. Maiden name Mary J. Adams

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

16. (a) Informant Helma Brown

(b) Address 812 Richmond Rd. Joplin, Mo.

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

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

17. (a) Warrensburg (b) Date thereof Jan 15 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Warrensburg, Mo

(b) Date of occurrence _____

18. (a) Signature of funeral director HARRISONVILLE, MO

(b) Address _____

(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? _____

19. (a) Jan 10, 1940 (b) Walter V. Robbins, M.D.
(Date recorded local registrar) (Registrar's signature)

153 While at work? _____ (Specify type of place) (e) Means of injury

23. Signature Walter V. Robbins (M. D. or other)

Address Peculiar, Mo Date signed 1/10/40

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

19
9
0

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

Ernest Rummelberger

Registered Apprentice No. 4

working under my personal supervision.

Signed

Ernest Rummelberger

Licensed Embalmer No. 13368

P. O. Address Harrisonville

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.