

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 15, 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH ✓

State File No. 2229

Registration District No. 956

Primary Registration District No. 5394

Registrar's No.

1. PLACE OF DEATH:

- (a) County Douglas
(b) City or town Clinton
(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) 5 3/6

3. (a) PRINT
FULL NAME

Mollie H. Canterbury

8. (b) If veteran,
name war

8. (c) Social Security
No. 1

4. Sex Female race White

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

6. (b) Name of husband or wife
W. W. Canterbury

6. (c) Age of husband or wife if
alive years
21 1836

7. Birth date of deceased
(Month) (Day) (Year)

Mar 21 1836

8. AGE:

Years

Months

Days

If less than one day

83

7

26

by min.

9. Birthplace

Monroe Co. Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation

House Keeper

11. Industry or business

MOTHER FATHER

12. Name John Malone

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

14. Maiden name Unknown

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

16. (a) Informant's own signature

Ollie Canterbury

(b) Address

3400 1st St

17. (a) Buried
(Burial, cremation, or removal)

(b) Date thereof 1/17/45
(Month) (Day) (Year)

(c) Place: burial or cremation

Macedonia

18. (a) Signature of funeral director

Edith Veltin

(b) Address

3400 1st St

19. (a) Jan. 24-40
(Date received local registrar)

(b) Mr. Allen Rankin
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Douglas
(c) City or town Rural
(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 Jan day 17
year 1940 hour 8 minute 300P M.

21. I hereby certify that I attended the deceased from
_____, 19____, to _____, 19____;
that I last saw her alive on Nov-24-1939, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Learned Jan-19-1940-10Am
that patient was buried
Due to Did not see patient so
is impossible to state
Due to Cause of death. Have
not seen her since Nov-24-39
Other conditions Erbanele
(Include pregnancy within 3 months of death) Jan-19-1940

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically

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

23. Signature (M. D. or other)
Address Date signed

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **2229**
Registrar's No. **37**

Registration District No. **956**

Primary Registration District No. **5394**

1. PLACE OF DEATH:

(a) County **Douglas**
(b) City or town **Clinton T. P. (Clinton)**
(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)

3. (a) PRINT FULL NAME

Mollie H. Canterbury

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **and**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **83** Months **7** Days **26** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business

12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) **8-22-1940** (b) **Reba King White**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 **Jan** day **17** year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury **Local**
23. Signature **Reba King White** (M. D. or other) **Reg**
Address **Ava, Mo** Date signed **8-22-40**

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

SUPPLEMENTAL

