

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

FILED FEB 13 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3190

Registration District No. 609

Primary Registration District No. 4343

Registrar's No. 15

1. PLACE OF DEATH: 1

(a) County NEWTON

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

(c) Name of hospital or institution: SALE BOWMAN HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 weeks

In this community 6 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARY ETTA MESSER

3. (b) If veteran, name war _____

3. (c) Social Security No. 500-01-4382

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife WILLIAM FRANK MESSER

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

7. Birth date of deceased January 3 1916
(Month) (Day) (Year)

8. AGE: Years 24 Months 0 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Two County, Nebraska
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

FATHER { 12. Name Theodore Herring

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

MOTHER { 14. Maiden name HATTIE FRENZEL

15. Birthplace NEBRASKA CITY Nebraska
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hazel Green

(b) Address Neosho, Mo.

17. (a) Burial (b) Date thereof Jan 20 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HAZEL GREEN

18. (a) Signature of funeral director Early Thompson

(b) Address Neosho, Mo.

19. (a) Feb 3, 1940 (b) Orval R. Salvo, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEWTON

(c) City or town NEOSHO
(If outside city or town limits, write "RURAL")

(d) Street No. HILL STREET
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17
year 1940 hour 6 minute 30 P M.

21. I hereby certify that I attended the deceased from Dec 14
1939 to Jan 17 1940;
that I last saw h alive on Jan 17 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Labar pneumonia
right side Duration _____

Due to _____

Due to _____

Other conditions Specific infection of
(Include pregnancy within 3 months of death)
Both tubes

Major findings: none

Of operations _____

Of autopsy Right Labar pneumonia
pericarditis, Langrene of both tubes

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 _____

23. Signature Malvin P. Bowman (M. D. or other)

Address Neosho, Mo. Date signed 2-3-40

FORM 1 X 1931

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.

RECEIVED

District Health Officer No. 6,

District File Number 2410-2411

Date Filed FEB 13 1940

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

Gail K. Gay, Registered Apprentice No. 189
working under my personal supervision.

Signed Barley Thompson

Licensed Embalmer No. 3259

P. O. Address Neosho Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31907

Registrar's No. 15

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH

(a) County Newton
(b) City or town Newark
(c) Name of hospital or institution: St. Elizabeth's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: 3 m In hospital or institution (Specify whether
In this community 3 m years, months or days)

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.

3. (a) PRINT FULL NAME

Mary E. Messer

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years 24

Months _____

Days _____

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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan - day 17 - year 40
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive or _____ and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia Duration _____

Due to _____

Due to bronchopneumonia

Other conditions specific infection of both tubercles
(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 _____

23. Signature Melvin Brown (M.D. or other) _____

Address Newark Mo. Date signed _____

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

SUPPLEMENTARY

S-3190