

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3409
 Do not use this space.

1. PLACE OF DEATH

(a) County Palls Registration District No. 209
 (b) Township Washington Primary Registration District No. 6938
 (c) City Washington (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

(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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rolla Ingram
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 26 1920
 7. AGE YEARS 39 MONTHS _____ DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. H-W
 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) Palls Co. Mo. (STATE OR COUNTRY) _____

FATHER 13. NAME Charley Fellers 14. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME Della Laid 16. BIRTHPLACE (CITY OR TOWN) Palls Co. (STATE OR COUNTRY) _____

17. INFORMANT Rolla Ingram (ADDRESS) Washington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington DATE Feb 25 1939

19. FUNERAL DIRECTOR (NAME) Wuthorn Blue (ADDRESS) Balsam Mo.

20. FILED Jan 20 1940 Veda Melracken Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 24 1939
 22. I HEREBY CERTIFY, That I attended deceased from February 26, 1939, to March 24, 1939
 I last saw her alive on March 23, 1939 Death is said to have occurred on the date stated above, at 1-P.M.
 The principal cause of death and related causes of importance were as follows:

Brain abscess
Subarachnoid hemorrhage Date of onset Mar. 8, 1939

Other contributory causes of importance: _____

Name of operation none Date of _____
 What test confirmed diagnosis? Spinal puncture 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? no
 If so, specify _____
 (Signed) H. H. Covernan, M. D.
 (Address) Humansville, Mo.

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

Director Health Officer No. 7

1940

2-40-254
2-13-40

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.....

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.