

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

4157
Do not use this space.

1. PLACE OF DEATH

(a) County Monroe Registration District No. 902
(b) Township Smith Primary Registration District No. 4544 Registered No. _____
(c) City Alleendale (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

MARGARET KIDNEY

(a) Residence, Smith, Jess. world Co (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF M. O. Kidney
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 11, 1910
7. AGE YEARS 79 MONTHS 11 DAYS 6 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) (STATE OR COUNTRY) Alleendale Mo.

FATHER 13. NAME Luther Jackson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER 15. MAIDEN NAME Mary Washburn

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alleendale Mo.

17. INFORMANT (ADDRESS) Curtis Jackson
Franklin City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Michaels DATE 1/20 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. C. Dumble
Franklin City, Mo.

20. FILED 218 1940 Franklin City, Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-17 1940

22. I HEREBY CERTIFY, That I attended deceased from 5-5 1938, to 1-17 1940. I last saw her alive on 1-16 1940. Death is said to have occurred on the date stated above, at 8:00 a. m. The principal cause of death and related causes of importance were as follows:

Stenomania
2000
108
Other contributory causes of importance: Cerebral Haemorrhage

Date of onset 1-14-40
138

Name of operation _____ Date of _____
What test confirmed diagnosis Diagnosis Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? X Date of injury X 19____
Where did injury occur? X (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) Thomas M. D. M. D.
(Address) Franklin City, 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.

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 Arch C. Dumble

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

4167
Do not use this space.

1. PLACE OF DEATH *Worth*
(a) County *Worth* Registration District No. *903*
(b) Township *Smith* Primary Registration District No. *4544* Registered No. _____
(c) City *allendale* (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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 *Margaret Kidney*
(a) Residence, No. *Smith Pop. Worth Co.* St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *7* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *wid*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1-17* 19*40*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from 19... to ... 19...
I last saw him... alive on ... 19... Death is said to have occurred on the date stated above, at ... m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *79 11 6*

Date of onset

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

Name of operation Date of

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis? Was there an autopsy?

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19...

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury

PLACE DATE 19...

Nature of injury

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? If so, specify

20. FILED *Mar 21, 1940 Clifford Hase* Local Registrar

(Signed) *P. J. Ross*, M. D.

(Address) *Grand City Mo*

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

