DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 6428

Registration District No. FILED MAR 24 1940

Primary Registration District No. 5336

Registrar's No.

**1. PLACE OF DEATH:**

(a) County Dallas Jackson

(b) City or town R-2 Elkland Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2
(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 Dallas

(c) City or town Elkland Rt 2
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

3. (a) PRINT FULL NAME MATTIE C. BECK

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife S.M. Beck 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Mch (Month) 2 (Day) 1870 (Year)

8. AGE: Years 69 Months 11 Days 13 If less than one day ____ hr. ____ min.

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

10. Usual occupation House wife 0

11. Industry or business ____

FATHER
12. Name Samuel Hendrickson
13. Birthplace ____ (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Francis Cheek
15. Birthplace ____ (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature Chloe Gott
(b) Address R-2 Elkland Mo

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2-18-40 (Month) (Day) (Year)
(c) Place: burial or cremation Buffalo

18. (a) Signature of funeral director Dunn
(b) Address Springfield Mo

19. (a) 2-19, 1940 (Date received local registrar) (b) Mrs I N Shewmake (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 2 day 16 year 1940 hour 3 00 minute a M.

21. I hereby certify that I attended the deceased from 2-10-1940, 19__, to 2-16-, 1940; that I last saw her alive on 2-15-, 1940; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Coronary Thrombosis | 6 days |
| 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) no
(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? —
(Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature R.E. Harrell (M. D. or other) MD
Address Buffalo, Mo Date signed 2-16-40

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Rev. 5-17-39 1 X19511

RECEIVED
District Health Officer No. 7,
District File Number 2-40-321
Date Filed 2-29-40

## 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 Floyd W Fox

Licensed Embalmer No. 2910

P. O. Address 629 W. Walnut

**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.**

No. 2B
..-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 6428

Registration District No. 243 Primary Registration District No. 3336 Registrar's No.

**1. PLACE OF DEATH:**

(a) County Dallas

(b) ~~City or town~~ Jackson Twp (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 years, months or days)

In this community

3. (a) PRINT FULL NAME Mattie C. Beck

3. (b) If veteran, name war

3. (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 years

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

8. AGE: Years 69 Months 11 Days 13 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 2-19-1940 (b) Mrs J N Shewmaker (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Dallas

(c) City or town Elkland, R. 2 (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 2 day 16 year hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| 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? (Specify type of place)

While at work (e) Means of injury

23. Signature R. T. Hazrell (M. D. or other)

Address Buffalo Mo Date signed

SUPPLEMENTARY