

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 CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **6769**Registration District No. **363**Primary Registration District No. **5508**

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County **Hickory**
 (b) City or town **Rural-Madison**
(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 **5 1 1/2**

3. (a) PRINT FULL NAME

Hella Mae Samples

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex **fm**5. Color or race **wht**6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife

Henry

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

Oct 28 1887
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

52**3****16**

hr.

min.

9. Birthplace

Quincy
(City, town, or county)**MO**
(State or foreign country)

10. Usual occupation

Wife

11. Industry or business

MOTHER FATHER

12. Name

Marion Fallowell

13. Birthplace

England
(City, town, or county)**MO**
(State or foreign country)

14. Maiden name

J. D. Batcher
(City, town, or county)**MO**
(State or foreign country)

15. Birthplace

Missouri
(City, town, or county)**MO**
(State or foreign country)

16. (a) Informant's own signature

Hella Mae Samples

(b) Address

Quincy Mo

17. (a)

Buried
(Burial, cremation, or removal)**7/17/1940**
(Date thereof) (Month) (Day) (Year)

(c) Place: burial or cremation

Bernard Chapel

18. (a) Signature of funeral director

J. L. Luster

(b) Address

Wheatland, MO

19. (a)

Feb. 24
(Date received local registrar)(b) **Mabel O. Standiford**
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mo** (b) County **Hickory**
 (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 **Feb** day **14**
year **1940** hour **2** minute **00 P.**M.

21. I hereby certify that I attended the deceased from

Dec-1- 19**39**, to **Feb-14** 19**40**
that I last saw **her** alive on **Feb-1-** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma of Breast

Duration

18 monthsDue to Due to

Other conditions

None
(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) (e) Means of injury

23. Signature

A. S. Johnston(M. D. or other)

Address

Wheatland MoDate signed **2-20-40**

RECEIVED
District Health Officer No. 1
2-19-40
Date Filed

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 J.P. Lacey
Licensed Embalmer No. 2982
P. O. Address Wheatland

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.