

6772

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

9

Registration District No. 339

Primary Registration District No. 4212

1. PLACE OF DEATH:

(a) County Hickory
(b) City or town Rural - Weaubleau
(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 Hickory
(c) City or town Rural - Weaubleau
(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 6
year 1940 hour 3 minute 00 M.

21. I hereby certify that I attended the deceased from Jan 20, 1940, to Feb 6, 1940,
that I last saw her alive on Feb 5, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy no

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 D. E. D. Brown (M.D. or other) DO
Address Callina Date signed 2/9/40

PHYSICIAN
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Mary Elizabeth Rogers

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

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

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

7. Birth date of deceased Feb 26, 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Wife

11. Industry or business _____

12. Name Piley P. Overton

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

14. Maiden name Ann

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

16. (a) Informant's own signature M. E. Stogard

(b) Address Public Colo

17. (a) Burial (b) Date thereof 2/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robinson

18. (a) Signature of funeral director J. L. Lueker

(b) Address Wheatland Mo

19. (a) 3/9-40 (b) Jesse V. Owens
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

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

MARGIN RESERVED FOR BINDING
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.

50M-5-17-39
Rev. 5-17-39
I 143311

RECEIVED Officer No. 7,
District Health 3-40-434
License No. Number 3-11-40
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. R. Luckey

Licensed Embalmer No. *2984*

P. O. Address *Wheatland 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.