

S. N. 39  
1-21492

STANDARD CERTIFICATE OF DEATH

State File No. 6854

FILED MAR 16 1940

Registration District No. 398

Primary Registration District No. 3019

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Indep Sanitarium  
(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 1/2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Independence  
(If outside city or town limits, write "RURAL")  
(d) Street No. 620 No. River Blvd  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Bessie H. Yeager

3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. none

4. Female 5. Color White 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 Nov. 18 - 1874  
(Month) (Day) (Year)

8. AGE: 65 Years 1 Months 18 Days If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Interviewer

11. Industry or business No State Employment

12. Name Samuel J. Dutton

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

14. Maiden name Melba Shelby

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

16. (a) Informant Henry H. Yeager

(b) Address 620 No. River Blvd

17. (a) Burial (b) Date thereof 7/9/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Washington Cem.

18. (a) Signature of funeral director George C. Carson

(b) Address Independence, Mo.

19. (a) Feb 7 1940 (b) F. L. Cook  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 6  
year 1940 hour 1 minute 10 P.M.

21. I hereby certify that I attended the deceased from Jan 23, 1940, to Feb 6, 1940; that I last saw her alive on Feb 6, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Excess health with failure of a heart that had not been in auricular fibrillation

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: None  
Of operations \_\_\_\_\_

Of autopsy None

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 no

23. Signature Theresa L. Thompson (M. D. or other) MD  
Address Independence Mo Date signed 1-7-40

Duration 1 week

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

752

RECEIVED

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

*Raymond Martin*

Registered Apprentice No.

*199*

working under my personal supervision.

Signed

*John Marion Stein*

Licensed Embalmer No.

*3156*

P. O. Address

*Ind. P. 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6854  
Registrar's No. 45-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 398

Primary Registration District No. 3019

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(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)

3. (a) PRINT FULL NAME

Bessie H Zeager

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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 65 Months 1 Days 18 If less than one day \_\_\_\_\_ h. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(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 6 year 1940 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.

Immediate cause of death Encephalitis with failure of a heart that at first was in senile fibrillation

Due to Not epidemic encephalitis at account to a recurrence of a former encephalitis  
(Include pregnancy within 9 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Russell Ethenhausen (M.D. or other) \_\_\_\_\_  
Address Independence \_\_\_\_\_ signed \_\_\_\_\_

SUPPLEMENTAL

S-6854