

Registration District No. 70009 9-1940

Primary Registration District No. 4408

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Bowling Green
(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 Ora Elizabeth Traynor
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William Traynor 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 8 1875
(Month) (Day) (Year)

8. AGE: Years 64 Months 10 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Egra Martin
13. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Martha Boyd
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature William Traynor

(b) Address Bowling Green Mo

17. (a) Burial (b) Date thereof 2-6-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Noix Creek Cem

18. (a) Signature of funeral director Grace Bumpstead

(b) Address Bowling Green Mo

19. (a) 1-11-40 (b) M. Summer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pike
(c) City or town Bowling Green
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4 year 1940 hour 4 minute 2 M.

21. I hereby certify that I attended the deceased from July, 1920, to Feb 4, 1940
that I last saw him alive on 2-3-40, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis
Duration _____

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? _____

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

23. Signature T. H. Winters (M. D. or other) _____

Address Bowling Green Mo Date signed 2-4-40

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

Rev. 5-17-39
U.S. GOVERNMENT PRINTING OFFICE: 1938

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.

RECEIVED

District Health Officer No. 10

District File Number 2-40-480

Date Filed MAR 5 1940

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 Grace Paul Reed

Licensed Embalmer No. 2204

P. O. Address Bushy Creek, Pa.

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.