MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

FILED MAR 9 - 1940

7847
Do not use this space.

1. PLACE OF DEATH
(a) County Putnam — Registration District No. 720
(b) Township Grant — Primary Registration District No. 6234
(c) City Livonia — (d) Street No. 37 (If death occurred in Hospital or Institution, write its name instead of street and number) — St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 1

2. PRINT FULL NAME NANCY JANE BISWELL

(a) Residence, No. LIVONIA, MO. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF James Biswell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 15, 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	80	1	24	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. housewife
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Schuyler, Co. Mo.

FATHER
13. NAME Jacob Biswell
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Tipton
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Oscar Biswell Livonia Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Johns DATE Feb. 11 1940

19. FUNERAL DIRECTOR (NAME) Moreheads' (ADDRESS) Lancaster, Mo. 647

20. FILED Mch 1 1940 E. E. McClellan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 9, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan. 3d, 1940, to Feb. 9, 1940
I last saw h.er alive on Jan. 26, 1940. Death is said to have occurred on the date stated above, at 10.10 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage with hemiplegia of right side	Feb. 4, 1940
Related Causes A fall Sept. 12, 1939 with severe injury to r. shoulder and knee, from which she never recovered; and which was followed by marked physical and mental deterioration, with confusional delirium for 2 months.	

Other contributory causes of importance:
Name of operation Date of
What test confirmed diagnosis? Phys. exam. Was there an autopsy? no.
Contributory Cause

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury Sept. 12, 1939
Where did injury occur? Livonia, Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
In her home.
Manner of injury Fall
Nature of injury Diagnosed as sprain r. shoulder.

24. Was disease or injury in any way related to occupation of deceased? no.
If so, specify

(Signed) Isaac M. Multon, M. D.
(Address) Lancaster, Mo.

Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS 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.

BOM-1-12-38 1 X14028

RECEIVED
District Health Officer No. 10
District File Number 3-40-521
Date Filed MAR 4 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.....

Licensed Embalmer No.....

P. O. Address.....

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
2-21-40

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. 7847

Registration District No. 720 Primary Registration District No. 6234 Registrar's No. 1

1. PLACE OF DEATH:
(a) County Putnam
(b) City or town Grant
(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)

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.

3. (a) PRINT FULL NAME Nancy Ann Biswell
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 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 80 | Months 1 | Days 24 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Jacob Biswell
13. Birthplace Dont Know (City, town, or county) (State or foreign country)
14. Maiden name Tipton
15. Birthplace Dont Know (City, town, or county) (State or foreign country)

16. (a) Informant Oscar Biswell
(b) Address Livonia Mo

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) Feb 1 40 (Date received local registrar) (b) E. E. McClellan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9
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.

	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 Ida M Rumbler (M. D. or other)
Address Lancaster Mo Date signed

SUPPLEMENTARY