

FILED MAR 21 1940 STANDARD CERTIFICATE OF DEATH

Registration District No. 749 Primary Registration District No. 4450

Registrar's No.

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Lesterville Mo.
(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
In this community years, months or days

3. (a) PRINT FULL NAME Martha Emma Lester 236
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex fem.
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife George Lester
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 11, 1871

8. AGE: Years 68 Months 7 Days 10 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

12. Name James Lewis
13. Birthplace Jefferson Co., Mo. (City, town, or county) (State or foreign country)
14. Maiden name Emaline Sullins
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant G. D. Lester
(b) Address Lesterville Mo.

17. (a) burial (b) Date thereof Feb. 22, 40 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Reyfield Cem.

18. (a) Signature of funeral director Norman White & Sons
(b) Address Ironton Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds
(c) City or town Lesterville Mo.
(d) Street No.
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from Feb 1, 1940, to Feb 21, 1940, that I last saw her alive on Feb 18, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death influenza Duration 2 1/2 days

Due to
Due to
Other conditions asthma (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations
Of autopsy

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature B. M. Fitzpatrick (M. D. or other)
Address Lesterville Mo Date signed 2/27/40

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

90

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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 240348

Licensed Embalmer No.....

Date Filed 3 20 40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7921

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 749

Primary Registration District No. 4450

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Leateville mo
(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 Martha Emma Heater

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 m

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 68 Months 7 Days 10 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 _____

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) 2/25/40 (b) C. M. Fitzpatrick (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.

20. DATE OF DEATH Month Feb day 21 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 _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 C. M. Fitzpatrick (M. D. or other)

Address Leateville mo

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

