

Registration District No. **33** Primary Registration District No. **1004**

**1. PLACE OF DEATH:**  
(a) County St. Francois  
(b) City or town Leadwood  
(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** EVELYN BALDWIN 435  
**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** widow  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if** \_\_\_\_\_  
alive \_\_\_\_\_ years  
**7. Birth date of deceased** Dec 25 1864  
(Month) (Day) (Year)

**8. AGE:** Years 75 Months 1 Days 11 If less than one day \_\_\_\_\_  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

**10. Usual occupation** None

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

**12. Name** Richard Riley  
**13. Birthplace** Ky.  
(City, town, or county) (State or foreign country)

**14. Maiden name** Henny McQuinn  
**15. Birthplace** Ky.  
(City, town, or county) (State or foreign country)

**16. (a) Informant's own signature** Mr Baldwin  
**(b) Address** Leadwood

**17. (a)** \_\_\_\_\_ **(b) Date thereof** 2-7-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Parkview Cemetery  
**18. (a) Signature of funeral director** Leadwell Bros  
**(b) Address** Flat River mo

**19. (a)** 2/10/40 **(b)** W. C. Bucher  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County St. Francois  
(c) City or town Leadwood  
(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 February day 5th  
year 1940 hour 5 minute 20 A. M.  
**21. I hereby certify that I attended the deceased from** Jan. 31, 1940  
22. Summary 1940 to February 5, 1940  
that I last saw her alive on February 4, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Pneumonia (hypostatic) 40 days

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations 10  
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** Anna Traub (M. D. or other) \_\_\_\_\_  
**Address** Leadwood **Date signed** 2/7/40

MARGIN RESERVED FOR BINDING

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **7992**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **38**

Primary Registration District No. **6024 B**

Registrar's No. **1**

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

1. PLACE OF DEATH:

(a) County **San Francisco**  
(b) City or town **Rancho**  
(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

**Evelyn Baldwin**

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 **75**

Months **1**

Days **11**

If less than one year \_\_\_\_\_ 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 \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

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

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

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

19. (a) \_\_\_\_\_

(Date received local registrar)

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

(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 **5** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to **pneumonia**

Due to **lobar**

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) (f) Means of injury \_\_\_\_\_

23. Signature **Arnold** \_\_\_\_\_ (Name of other) \_\_\_\_\_

Address **Leadwood** \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

**4 days**

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

