

FILED MAR 15 1940

8387

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Stone
 (b) City or town Rural Grant Twp
 (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 7.6.4

3. (a) PRINT FULL NAME Madeline Lois Hessinger

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar. 5-1939
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
11 18 hr. _____ min.9. Birthplace Mo. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name John Hessinger13. Birthplace Kansas (City, town, or county) (State or foreign country)14. Maiden name Clarys Rogers15. Birthplace Mo. (City, town, or county) (State or foreign country)16. (a) Informant John Hessinger(b) Address Marionville R#117. (a) Burial (b) Date thereof Feb. 24-1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Marionville Cem18. (a) Signature of funeral director J. W. Maples(b) Address Clever, Mo. 716219. (a) Feb. 24 1940 (b) H. G. Shannon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stone
 (c) City or town Marionville R#1
 (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 23
year 1940 hour 6 minute 30 A. M.21. I hereby certify that I attended the deceased from February 19
1940, to February 24, 1940,
that I last saw her alive on February 27, 1940,
and that death occurred on the date and hour stated above.Immediate cause of death
Bi-lobed - Broncho-Pneum. Duration 6 days

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 H. G. Shannon (M. D. or other) _____Address Clever, Mo. Date signed 2-23-40

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

RECEIVED

District Health Officer No. 6,

District File Number

3210-860

Date Filed MAR 14 1940

1972

U.S. GOV
HEALTH DEPT
WASHINGTON, D.C.

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 J. W. Maple

Licensed Embalmer No. 2985

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. 8387

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 846

Primary Registration District No. 6105

Registrar's No. 6

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

1. PLACE OF DEATH—
 (a) County Stone
 (b) City or town Grant Rural
 (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 Madine Lois Kessinger
 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 ✓
 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 Months Days If less than one day
11 18 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 _____
 (Burial, cremation, or removal) (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.

20. DATE OF DEATH Month Feb day 23
 year _____ 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 Bilateral Bronchopneumonia
 Due to no complications
 Due to either prior or following pneumonia
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____
 1974

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) _____ (e) Means of injury _____
 23. Signature A.P. Capetta (M. D. or other) _____
 Address Crane _____ Date signed _____

SUPPLEMENTARY

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

