

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

8525
 Do not use this space.

FILED MAR 14 1940

1. PLACE OF DEATH

(a) County Washington Registration District No. 887
 (b) Township Union Primary Registration District No. L-189 Registered No. _____
 (c) City _____ or _____
 (d) Street No. _____ 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.

2. PRINT FULL NAME

(a) Residence, No. Cadet mo R-1 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>widowed</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 29 1860</u>		
7. AGE YEARS <u>79</u>	MONTHS <u>8</u>	DAYS <u>6</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		IF LESS than 1 day, _____ hrs. or _____ min.
9. Industry or business in which work was done, as saw mill, bank, etc. <u>House work</u>		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Washington Mo</u>		
13. NAME <u>Eliza Bayer</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Washington Mo</u>		
15. MAIDEN NAME <u>Mary Bayer</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Washington Mo</u>		
17. INFORMANT (ADDRESS) <u>Ed Myers of Union old miners mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Edmines</u> DATE <u>Mar 7 1940</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Sparks Palace mo</u>		
20. FILED <u>Mar 6 1940</u> <u>Ed Cresswell</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 5 1940

22. I, HEREBY CERTIFY, That I attended deceased from Front St 2540 March 4 1940
 I last saw her alive on Mar 1 1940 Death is said to have occurred on the date stated above, at 12 P m.
 The principal cause of death and related causes of importance were as follows:
Pneumonia
 Other contributory causes of importance:
Influenza

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Ed Cresswell M. D.
Palat, Mo (Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

50M-9-19-38 I X18603

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.

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.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 85-25-7

Registration District No. 887

Primary Registration District No. 6187

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Union
(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 Frozen Theban

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 wd

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 79 Months 8 Days 6 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 1-40 (b) G. F. Creswell
(Date received local registrar) (Registrar's signature)

MEANS OF CERTIFICATION

20. DATE OF DEATH month 3 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 _____

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 G. F. Creswell (M. D. or other) _____

Address Patton Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL COPY

