

Registration District No. 900

Primary Registration District No. 6207

Registrar's No.

1. PLACE OF DEATH:

(a) County Webster 1
(b) City or town Niangua 1
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X (Specify whether life)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster
(c) City or town Niangua
(If outside city or town limits, write "RURAL")
(d) Street No. 7-0
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Shirley Ann Elmore 456

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

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

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

7. Birth date of deceased August 26, 1936
(Month) (Day) (Year)

8. AGE: Years 3 Months 4 Days 12 If less than one day X hr. X min.

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

10. Usual occupation Child

11. Industry or business X

MOTHER FATHER
12. Name Omar Elmore
13. Birthplace Webster Co., Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Rachael Wood
15. Birthplace Fulton Co., Arizona
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J.V. Elmore

(b) Address Niangua, Missouri

17. (a) Burial (b) Date thereof Jan. 10-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Niangua, Missouri

18. (a) Signature of funeral director _____

(b) Address Marshfield, Missouri

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8
year 1940 hour 8 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from Jan - 1 - 1940 to Jan 10 - 1940
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Spinal-meningeal meningitis

Due to Influenza fever

Due to _____

Other conditions (include pregnancy within 3 months of death) HP

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 W.F. Schlicht (M. D. or other) _____
Address Niangua Mo Date signed 3-11-40

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

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

Rev. 5-17-39

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. 3312

P. O. Address Marshfield, Mo.

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. 8530

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 900

Primary Registration District No. 6207

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Webster

(b) City or town Trangua, 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 _____ (Specify whether _____)

3. (a) PRINT FULL NAME Shirley Ann Elmore

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 8

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 3 Months 4 Days 12 If less than one day _____ 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) _____ (b) Sullivan Schlecht (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 Jan day 8 year 1970 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ 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) _____ (Means of injury)

23. Signature W. F. Schlecht (M. D. or other) _____

Address Trangua, Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

