

1940 MARCH 20 1940

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

8582
Do not use this space.

1. PLACE OF DEATH ?

(a) County Wright Registration District No. 908
(b) Township Mountain Grove Primary Registration District No. 6222 Registered No. 13
(c) City (d) Street No.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Irena May Mabeles

(a) Residence, No. 120 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug -30-1936

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
3 5 22

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Mountain Grove, Mo. (STATE OR COUNTRY) Wright County

FATHER
13. NAME Lester Mabeles

14. BIRTHPLACE (CITY OR TOWN) Wright County, Mo. (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME Alvina Proch

16. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY)

17. INFORMANT Stella Clavin (ADDRESS) Mountain Grove, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Buried DATE Feb 23 1940

19. FUNERAL DIRECTOR (NAME) Russell Barber (ADDRESS) Mountain Grove, Mo.

20. FILED 2-25 19 40 Bernice Montgomery Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 22 - 1940

22. I HEREBY CERTIFY That I attended deceased from Feb 21, 1940, to Feb 22, 1940

I last saw her alive on Feb 23, 1940 Death is said to have occurred on the date stated above, at 4 P. m.
The principal cause of death and related causes of importance were as follows:

Brain Tumor Date of onset ?

Other contributory causes of importance:

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?
If so, specify

(Signed) W. A. Craig M. D.
(Address) Mountain Grove, Mo.

COPY TO BE FILED WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1-X16603

RECEIVED

District Health Officer No. 6,

District File Number 340-879

Date Filed MAR 15 1940

542

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. **8582**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **908**

Primary Registration District No. **6222**

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Wright

(b) City or town Inter Grove Ins
(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 _____)
years, months or days

3. (a) PRINT FULL NAME Gene May Mabe

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 x

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 8 Days 22 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)

(Burial, cremation, or removal)

(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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 22 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 Brain Tumor

Due to 7.7.1940

Due to _____

Other conditions (Include pregnancy within 3 months of death) 55

Major findings: Of operations _____

Of autopsy _____

Duration _____

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 W. A. Cray (M. D. or other) _____

Address Mountain Grove Ins signed _____

SUPPLEMENTAL

