

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.

APR 17 1940

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

10141
Do not use this space.

1. PLACE OF DEATH

(a) County Bollinger Registration District No. 69
 (b) Township Waxhaw Primary Registration District No. 5102 Registered No. 18
 (c) City Greenbrier (d) Street No. _____ St.
 (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

(a) Residence, No. Greenbrier, Mo. 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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 2
 6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 29, 1940
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X X X 12

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) (STATE OR COUNTRY) Greenbrier, Mo.

13. NAME Harrison Cato
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greenbrier, Mo.

15. MAIDEN NAME Martha Swick
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) Harrison Cato
Greenbrier, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Cato Cemetery DATE April 12, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Shirley Morgan
Advance, Mo.

20. FILED 19 Mrs. Jake Berry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 11, 1940

22. I HEREBY CERTIFY, That I attended deceased from March 29, 1940, to April 11, 1940

I last saw her alive on April 6, 1940. Death is said to have occurred on the date stated above, at 3 A. m.

The principal cause of death and related causes of importance were as follows:

Miscellaneous and Prematurity

Date of onset

Other contributory causes of importance:

7 months baby born in home with measles

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) E. C. Masters (Address) Advance, Mo. X.D.O.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 10141Registration District No. Ballinger Primary Registration District No. 2108Registrar's No. 18

1. PLACE OF DEATH:

- (a) County Ballinger
(b) City or town Hayhe
(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 Carol Marie Cato

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 min. 12

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

10. Usual occupation

11. Industry or business

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

- (a) Signature of funeral director (b) Address

19. (a) 10/12-1940 (b) Mrs. John 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 apr day 11 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

- that 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 (M. D. or other) Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECORD
Y-USE UNFADING BLACK INK-MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 10141

Registration District No. 69

Primary Registration District No. 3108

Registrar's No. 39

1. PLACE OF DEATH:
(a) County Bollinger
(b) City or town Wayne
(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
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Carol Marie Cato
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
7. Birth date of deceased May 29 1940
(Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

12. Name Harrison Cates

13. Birthplace Greenbrier
(City, town, or county) (State or foreign country)

14. Maiden name Dorothy Sarah

15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Harrison Cates

(b) Address Greenbrier

17. (a) (b) Date thereof Apr 12-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cato Cem

18. (a) Signature of funeral director
(b) Address

19. (a) 4/23-1940 (b) Mrs John B. Bink
(Water-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 Apr day 11
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
and that death occurred on the date and hour stated above.

Immediate cause of death measles's prematurity
Duration

Due to
Due to

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

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?

(Specify type of place) While at work (e) Means of injury

23. Signature E. C. Martin (M. D. or other)

Address Adrianne Date signed

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

PROVIDED