DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1940

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 10815

Registration District No. 2394

Primary Registration District No. 463

Registrar's No. 3

**1. PLACE OF DEATH:**

(a) County Dent

(b) City or town Bunker (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 about 7 years (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Dent

(c) City or town Bunker, Mo. (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 Cynthia Elizabeth Reason

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec. (Month) 20 (Day) 1939 (Year)

8. AGE: Years 80 | Months 5 | Days 18 | If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name Robert E. Neely

13. Birthplace Cape Co. (City, town, or county) Mo. (State or foreign country)

14. Maiden name Dora Knous

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

16. (a) Informant's own signature Mr. Sam Neely

(b) Address Ellington, Mo.

17. (a) Bay Sanitary (Burial, cremation, or removal) (b) Date thereof Dec. 21 (Month) (Day) (Year)

(c) Place: burial or cremation Bay Cemetery

18. (a) Signature of funeral director N. D. Nelson

(b) Address Salem Mo

19. (a) 12/21/39 (Date received local registrar) (b) Registrar's signature

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20 year 1939 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec. 13, 1939, to Dec. 20, 1939, that I last saw her alive on Dec 19, 1939, and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Lobar Pneumonia | |
| Due to Middle Lobe of right Lung | |
| Due to | |
| Other conditions no (Include pregnancy within 3 months of death) | |

Major findings:
Of operations

Of autopsy no

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature L. L. Henson M.D (M. D. or other)

Address Bunker, Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 1 x 10811

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

## 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.

RECEIVED
District Health Officer No. 5,

District File Number 440-4660

Date Filed 4/1/40

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.**

No. 2B
-2-21-40
X22859

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 10815

Registration District No. 95-4 Primary Registration District No. 4463 Registrar's No.

1. PLACE OF DEATH:
(a) County Dent
(b) City or town Bunker
(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 Cynthia Elizabeth Beason
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive 85 years

7. Birth date of deceased June (Month) 2 (Day) 1857 (Year)
Dec - 20 - 1939

8. AGE: Years 80 | Months 5 | Days 16 | 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) May 2 1940 (Date received by local registrar) (b) Mark Lukas Clerk (Registrar's signature)

SUPPLEMENTARY

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 20
year 1939 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.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 L. L. Henson (M. D. or other)
Address Bunker Date signed

S-10815

1940