

FILED APR 8 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10920

Registration District No. 314

Primary Registration District No. 4190

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Storbers  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether years, months or days) 70 years in Greene Co

8. (a) PRINT FULL NAME Jda Melissa Kies

3. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Sept 24 1863  
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 27 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER { 12. Name Donald MASH  
13. Birthplace Ind  
14. Maiden name Elizabeth Morgan  
15. Birthplace Ind

16. (a) Informant Mrs D. Hoskins  
(b) Address Storbers Mo

17. (a) Burial (b) Date thereof 3/24/1940  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Storbers

18. (a) Signature of funeral director Katyle A. Phillips  
(b) Address Storbers Mo

19. (a) 3/23/40 (b) R. F. Serner  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Greene  
(c) City or town Storbers 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21 year 1940 hour 11 minute 10 P. M.

21. I hereby certify, that I attended the deceased from Feb 19 38 1938 to March 21 1940

that I last saw her alive on March 21 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 3 day

Due to Senility + General Debility

Due to ✓  
Other conditions Cause of Fall  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: Of operations ✓  
Of autopsy ✓  
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? at home (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

(Specify type of place) at home  
While at work? ✓ (e) Means of injury fall

23. Signature R. F. Serner (M. D. or other) RD  
Address Storbers Mo Date signed 3-23-40

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

0608

52  
RECEIVED

District Health Officer No. 111

District File Number

440-423

Date Filed

APR 8 1918

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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

Lator H. Phillips

Licensed Embalmer No.

1898

P. O. Address

Stoubery Md

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. 10920

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 314

Primary Registration District No. 4190

Registrar's No.

1. PLACE OF DEATH:

(a) County Gentry  
(b) City or town Stanberry Town  
(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 Ida Melissa Hies

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 W  
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 76 Months 5 Days 27 If less than one day \_\_\_\_\_ min.

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 \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
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) \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month Mar day 21  
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 \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.  
Immediate cause of death Lobar pneumonia

Due to \_\_\_\_\_ 52  
Due to \_\_\_\_\_

Other conditions Cancer of face  
(Include pregnancy within 3 months of death)  
Major findings Primary site - left side of face  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 P. J. Melligan (M. D. or other) \_\_\_\_\_  
Address Stanberry Mo Date signed \_\_\_\_\_

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

SUPPLEMENTAL

1940

S-10920