

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

11199
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 402
 (b) Township Ant. A. Bar Primary Registration District No. 4237 Registered No. 84
 (c) City Oak Grove Mo (d) Street No. _____ St.
 (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.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME N. Ewing
 (a) Residence, No. _____ St. 14
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hennie Ewing
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 20, 1862
 7. AGE YEARS 77 MONTHS 10 DAYS 20 If LESS than 1 day, _____ hrs. or _____ min.

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. Adv. merchant
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 42 yrs.

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

FATHER 13. NAME Young Ewing

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Mary Masterson

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

17. INFORMANT (ADDRESS) M. H. Ewing Oak Grove Mo.

18. BURIAL, CREMATION, OR REMOVAL Pleasant Prairie DATE 2/12th 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Zouless Oak Grove Mo.

20. FILED Mar. 18, 1940 Mrs. A. H. Mann Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/10th 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1940 to Feb. 10, 1940
 I last saw him alive on Feb. 10, 1940 Death is said to have occurred on the date stated above, at 8 P.m.
 The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage (Pulmonary area) Date of onset 2-3-40
87W

Other contributory causes of importance:
High blood pressure 1935-
Arteriosclerosis 1932

Name of operation none Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? no

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 none
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) O. Lister M. D.
 (Address) Oak Grove Mo.

WRITE PLAINLY, 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.

APR 23 1940

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,

Zowess, or by

Registered Apprentice No....., working under my personal supervision.

Signed.....
Zowess

Licensed Embalmer No. *2352*

P. O. Address. *Oak Grove, 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.

Registration District No. 402

Primary Registration District No. 4237

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Oak Grove
(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 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Neander Chatamewing

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

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

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 77 Months 10 Days 20 If less than one day by 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) May 4 1940 (b) Mrs. A. H. Mann (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 2 day 10 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

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 O. Linton (M. D. or other)

Address Oak Grove Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940

S-11199