

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.

FILED APR 20 1940

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

11546
Do not use this space.

1. PLACE OF DEATH

(a) County Lewis Registration District No. 478
(b) Township Ewing Primary Registration District No. 4287 Registered No. 5-
(c) City Ewing or (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) 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.

2. PRINT FULL NAME

(a) Residence, No. _____ 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) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charley W. Haines
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 1, 1863
7. AGE YEARS 77 MONTHS 1 DAYS 27 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
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) Marceline, Illinois (STATE OR COUNTRY)

13. NAME Jessie Workman

14. BIRTHPLACE (CITY OR TOWN) Illinois (STATE OR COUNTRY)

15. MAIDEN NAME Sarah Stoker

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

17. INFORMANT Mrs M. E. Campbell (ADDRESS) Ewing, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Deeridge, Mo DATE Mar. 30, 1940

19. FUNERAL DIRECTOR (NAME) James A. Cook (ADDRESS) Lewistown, Mo

20. FILED 4-10, 19 40 Anna K. Ball Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 28, 1940

22. I HEREBY CERTIFY, That I attended deceased from March 15th, 1940, to March 28th, 1940
I last saw her alive on March 28, 9:30 P.M. Death is said to have occurred on the date stated above, at 9:30 P.M.,
The principal cause of death and related causes of importance were as follows:

Myocardial failure Date of onset _____

Other contributors, causes of importance: Senility

Name of operation none Date of none
What test confirmed diagnosis? none Was there an autopsy? none

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? none Date of injury none
Where did injury occur? none (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. none
Manner of injury none
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? none
If so, specify none
(Signed) Ernest W. Leable, D.O.
(Address) Ewing, Mo.

RECEIVED

District Health Officer No. 10

District File Number 4-40-842

Date Filed APR 15 1948

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 myself

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

Signed James A. Adams

Licensed Embalmer No. 2532

P. O. Address Lewis town, Md.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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. 11546

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 478

Primary Registration District No. 4287

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Lewistown
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County LEWIS
(c) City or town Ewing
(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 Mar day 28
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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

3. (a) PRINT FULL NAME

L. Sunday
Leah May Haines

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 wid

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
77 1 27 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) (Date received local registrar) (b) (Registrar's signature)

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? _____

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

23. Signature Guy W. Cable (M. D. or other)

Address Ewing Date signed _____

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

11546 (1940)