

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4

Registration District No. 481

Primary Registration District No. 4290

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Lewis

(b) City or town Lewistown Mo.

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days 15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis

(c) City or town Lewistown
(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 Mary Elizabeth Whit

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15
year 1940 hour 11 minute 50 P. M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife E. F. Whit

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased. Feb 16 1837
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 8
9, 1940 to March 15, 1940

that I last saw her alive on March 15, 1940
and that death occurred on the date and hour stated above

8. AGE: Years 83 Months _____ Days 29 If less than one day _____ hr. _____ min.

Immediate cause of death she had the influenza all so long history of bronchitis

Due to heart gave away to the lead

Due to _____

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

10. Usual occupation Housewife

Other conditions 11/15
(Includes pregnancy within 3 months of death)

11. Industry or business _____

12. Name Frank M. Daniel

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

14. Maiden name Maguire Rodgin

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

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs Mary Allen

(b) Address Lewistown

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

(c) Place: burial or cremation Lewistown

18. (a) Signature of funeral director Thomas Ball

(b) Address Elwing, Mo

19. (a) 3/16/40 (b) James A. Carter
(Date received local registrar) (Registrar's signature)

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? _____

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

23. Signature J. L. Coater (M.D. or other) _____
Address La Belle Mo Date signed 3-16

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.

RECEIVED

District Health Officer No. 10

District File Number 4-40-704

Date Filed APR 4 1950

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 Thomas Ball

Licensed Embalmer No. 1744

P. O. Address Ewing, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 115-49

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 481

Primary Registration District No. 4290

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Lewisport
(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 Mary Elizabeth Zelt

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 Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 83 Months - Days 29 If less than one day _____ hr. _____ 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 _____

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) 3/16/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 15
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)
(c) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address [Signature] Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

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

MOTHER FATHER

11549 (1940)