

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 5048 1149

Primary Registration District No. 5698

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Mc Donnell Co

(b) City or town Jennette 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 years, months or days) _____ (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mc Donnell

(c) City or town Rural
(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 LOUISE GRAY

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17 year 1940 hour 3:30 minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased Feb. 25 1940
(Month) (Day) (Year)

that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: Years _____ Months 3 Days 6 If less than one day _____ hr. _____ min.

Due to Found dead in bed probably the effects of pneumonia
R. M. O.

Due to _____

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

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name Margaret Gray

FATHER { 13. Birthplace Allen
(City, town, or county) _____ (State or foreign country)

14. Maiden name Margaret Waters
(City, town, or county) _____ (State or foreign country)

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

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

16. (a) Informant's own signature M. W. Rorenbaum

(b) Address Jennette Mo

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

(c) Place: burial or cremation Jennette cemetery

18. (a) Signature of funeral director Lee A. Carnell

(b) Address _____

19. (a) 3-17-40 (Date received local registrar) _____ (b) Lee A. Carnell (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? _____

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

23. Signature Lee A. Carnell (M. D. or other) _____

Address Jennette Mo Date signed 4-8-40

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.

RECEIVED

District Health Officer No. 6,

District File Number HHO-11239

Date Filed APR 15 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, or by.....

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

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11624

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1149

Primary Registration District No. 3698

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Pineville - Rural
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Mary Louise Gray

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 _____

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

Months

Days

If less than one day

3 weeks hr. min.

9. Birthplace

Pineville
(City, town, or county)

(State or foreign country)

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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-17-40

(Date received local registrar)

(b) Lee A. Carnell

(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

20. DATE OF DEATH

MEDICAL CERTIFICATION

men

Month 17 day _____
year _____ 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 _____

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)

(2) Means of injury _____

23. Signature Lee A. Carnell (M. D. or other) _____

Address Pineville _____ Date signed _____

SUPPLEMENTAL

11624 (1940)