

FILED APR 23 1940

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

11705
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 549
(b) Township Union Primary Registration District No. 5742 Registered No. 1
(c) City Union (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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

672 Margaret Emily Whright
(a) Residence, No. Marion, Mo. 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 Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb-9-1860
7. AGE YEARS 80 MONTHS 1 DAYS 21 IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
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. Domestic
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

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

FATHER
13. NAME James Shindlett

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

MOTHER
15. MAIDEN NAME Mary Paul

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

17. INFORMANT (ADDRESS) J. E. Whright
Union Mo. 674104

18. BURIAL, CREMATION, OR REMOVAL PLACE Union Cemetery DATE May 31 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Grove Johnson
Union Mo.

20. FILED Mar 30 1940 Mrs. C. F. Dipton local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 29 1940

22. I HEREBY CERTIFY, That I attended deceased from Mar 20 1940 to Mar 29 1940

I last saw him alive on Mar 29 1940 Death is said to have occurred on the date stated above, at 2:25 a.m.

The principal cause of death and related causes of importance were as follows:

Influenza Date of onset Mar 20

Other contributory causes of importance:

Bronchial Pneumonia Mar 25

Name of operation Chinical Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) D. Simpson, M. D.

490 (Address) Shelburna 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.

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 *ME*

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

Signed *George J. Givan*

Licensed Embalmer No. *1754*

P. O. Address *Hummelwell 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. 117058

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 549

Primary Registration District No. 2742

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Marion
(b) City Marion T.P.
(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

3. (a) PRESENT FULL NAME Margaret Emily Knight

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, 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 80 Months 1 Days 24 If less than one day _____ 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) Mar 30 '40 (b) Mrs. C.F. Tipton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
(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.

19. DECEASED'S CERTIFICATION
20. DATE OF DEATH: Months Mar day 29
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: Influenza

Due to _____
Due to _____

Other condition: Branchial Pneumonia
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
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?

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

23. Signature B. L. Simpson (M. D. or other)
Address Shelton has signed

SUPPLEMENTARY

11705 (1940)