

Registration District No. **3739** **1940**

Primary Registration District No. **4438**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Randolph**
(b) City or town **Huntsville Mo**
(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) **7**
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **50 yrs**
years, months or days **65-5**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Randolph**
(c) City or town **Huntsville Mo**
(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 **BETTIE, KIERNA**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **May 5 1889**
(Month) (Day) (Year)

8. AGE: Years **80** Months **10** Days **12** If less than one day _____ hr. _____ min.

9. Birthplace **Andrew Co** (City, town, or county) (State or foreign country)

10. Usual occupation **School Teacher**

11. Industry or business _____
12. Name **Robert I. Kierna**
13. Birthplace **Ireland** (City, town or county) (State or foreign country)
14. Maiden name **Margie Rose**
15. Birthplace **Randolph Co** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Miss Nora Kierna**
(b) Address **Huntsville Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Mar 31 1940** (Month) (Day) (Year)
(c) Place: burial or cremation **Huntsville**

18. (a) Signature of funeral director **Tom B. Fulton**
(b) Address **Huntsville Mo**

19. (a) **Apr-1-1940** (Date received local registrar) (b) **Wm. D. A. Traubert** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **27th**
year **1940** hour **8:30** minute **30 A.M.**
21. I hereby certify that I attended the deceased from **March 14th**, 1940, to **March 27th**, 1940, that I last saw her alive on **March 27th**, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneumonia** Duration **4 days**
Due to **Senility**
Due to **Fracture of Right Hip** **13 days**
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? **Yes**
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **J. H. Johnston** (M. D. or other) **M.D.**
Address **Huntsville Mo** Date signed **4/1/40**

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.

1862
1/10

RECEIVED

District Health Officer No. 10

District File Number 4-40-737

Date Filed APR-2-1940

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

Tom B. Patton

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 12123

Registration District No. 733

Primary Registration District No. 4438

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Huntsville
(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)

3. (a) PRINT FULL NAME Bettie Kiernan

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

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

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 10 Days 22 If less than one day _____ 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 Mar day 27 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia
senility

Due to _____
Due to fracture of right hip

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) Accident

(b) Date of occurrence March 14, 1940

(c) Where did injury occur? at home, Huntsville, Randolph, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

While at work _____ (Specify type of place)

(c) Means of injury Fallen floor

23. Signature D. H. Johnson (M. D. or other)

Address Huntsville, Mo. signed _____

SUPPLEMENTARY

1940

S-12123