

RECORDS DEPARTMENT - MISSOURI STATE BOARD OF HEALTH

FILED APR 23 1940

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

12566  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Schuyler Registration District No. 803  
 (b) Township Glenwood Primary Registration District No. 6049  
 (c) City..... (d) Street No. 2 Registered No. 83  
 (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 MARY EPPERSON  
 (a) Residence, No. 167 St. 0  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 TILENUS EPPERSON

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT. 31, 1869

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>70</u>	<u>5</u>	<u>0</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife  
 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) OHIO (STATE OR COUNTRY) 1

FATHER  
 13. NAME ISSAC JUMPER  
 14. BIRTHPLACE (CITY OR TOWN) OHIO (STATE OR COUNTRY) 1

MOTHER  
 15. MAIDEN NAME RUTH NORRIS  
 16. BIRTHPLACE (CITY OR TOWN) OHIO (STATE OR COUNTRY) 1

17. INFORMANT Chas Tadlock (ADDRESS) Glenwood, Mo.

18. BURIAL, CREMATION, OR REMOVAL Glenwood PLACE DATE April, 2, 1940  
Cemetery

19. FUNERAL DIRECTOR (NAME) Worcesters (ADDRESS) Stearns, Mo.

20. FILED Apr. 3, 1940 Byrd Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 31, 1940

22. I HEREBY CERTIFY, That I attended deceased from Sept, 1937, to Mar 31, 1940  
 I last saw her alive on Mar 29, 1940. Death is said to have occurred on the date stated above, at 11 P. m.  
 The principal cause of death and related causes of importance were as follows:  
Bronchial Pneumonia Date of onset Mar 29  
59  
 Other contributory causes of importance:  
Chronic Deafness 1937  
Diabetes

Name of operation..... 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? NO  
 If so, specify.....  
 (Signed) O. P. Lane M. D. 0  
 (Address) Independence City Mo

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.

I X14028

RECEIVED

District Health Officer No. 10

District File Number 4-46-799

Date Filed APR 10 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, .....

True & MINNIE MOREHEAD .....

, or by .....

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

Signed

*Morehead's*

Licensed Embalmer No. 3731-3680

P. O. Address

*Lancaster 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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 125-66

Registration District No. 805

Primary Registration District No. 6049

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Schuyler  
(b) City or town Stennord  
(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 Mary Epperson  
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 and  
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 70 Months 5 Days 0  
If less than one day \_\_\_\_\_ 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) \_\_\_\_\_ (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) April 2 (b) Mrs O P Farrington  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: Schuyler

(a) State Mo (b) County Becky  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 31  
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 \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature O. P. Farrington (M.D. or other) \_\_\_\_\_

Address Stennord Mo Date signed \_\_\_\_\_

SUPPLEMENTAL COPY

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

1940

1940

S-12566