

No. 2
1-10-39
17-39
X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **12605**

Registration District No. **827** Primary Registration District No. **4500** Registrar's No. **11**

1. PLACE OF DEATH:
 (a) County Shelby
 (b) City or town Clarence 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)
 (d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)
 In this community 40 years

8. (a) PRINT FULL NAME Marial Jane Dale **400**
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female race W 5. Color of W
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 19 1849
(Month) (Day) (Year)

8. AGE: Years 90 Months 8 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER { 12. Name John J. Humphrey
 13. Birthplace N.Y.
(City, town, or county) (State or foreign country)
 14. Maiden name Emma J. McConner
 15. Birthplace N.Y.
(City, town, or county) (State or foreign country)

16. (a) Informant Laura Martin

(b) Address Independence Mo

17. (a) Burial (b) Date thereof 2-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director E. H. Hopper

(b) Address Clarence Mo

19. (a) 3-8-1940 (b) Ray Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Shelby
 (c) City or town Clarence Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. South Center St
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5
 year 1940 hour 1 minute 10 A.M.

21. I hereby certify that I attended the deceased from Nov 1937
 _____, 19, to Mar. 1940, 19;
 that I last saw her alive on Mar 5 1940, 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy with right hemiplegia **5 day**

Due to cerebral thrombosis **6 days**

Due to _____ **7 1/2**

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none
 Of operations none
 Of autopsy none

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) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury no

23. Signature D. J. Hagan (M. D. or other) MD
 Address Clarence, Mo Date signed Mar 7 1940

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

220

RECEIVED

District Health Officer No. 10

District File Number 4-40-823

Date Filed APR 11 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 *E. A. Nipper*
Licensed Embalmer No. 878

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.