

APR 25 1940

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

12637
Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 834
 (b) Township Osage Primary Registration District No. 6097
 (c) City Near Bell City, Mo. (d) Street No. 1 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

Lena Elizabeth Cartwright
 (a) Residence, No. _____ 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 single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unmarried
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12/2, 1939
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 2 22
 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. None
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/4 1940
 22. I HEREBY CERTIFY, That I attended deceased from one day 1940, to 3/4 1940
 I last saw h. alive on 3/4, 1940 Death is said to have occurred on the date stated above, at 7 P. m.
 The principal cause of death and related causes of importance were as follows:
Malnutrition
 Date of onset _____

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Near Bell City, Mo.

FATHER
 13. NAME Doc Cartwright

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Blodgett Co., Mo.

MOTHER
 15. MAIDEN NAME Marion McCallum

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Near Bell City, Mo.

17. INFORMANT (ADDRESS) Doc Cartwright
Bell City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Walker Cemetery DATE Mar. 5 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edwin W. Mayer
Admission Mo

20. FILED 3/4 1940 D. S. McKeel Local Registrar.

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? Yes
 If so, specify _____

(Signed) C. O. Bennett M. D.
 (Address) Bell 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.

RECEIVED

District Health Officer No.

District File Number 440-9

Date Filed 4/8/46

STATEMENT TO BE MADE BY THE EMBALMER
FOR THE BODY OF
NAME OF DECEASED



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. 12637

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 834

Primary Registration District No. 6097

Registrar's No. 9

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

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Case Twp
(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

Lena Elizabeth Cartright

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 S

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
2 22 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) _____ (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 3 day 4
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

malnutrition

Due to some element or elements in the mother's milk,

Other conditions (Include pregnancy within 3 months of death) 156

Major findings: Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature C. O. Bennett (M. D. or other) _____

Address Bell City _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1940

S-12637