

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14588**

MAY 15 1940
Registration District No. **163**

Primary Registration District No. **5928**

Registrar's No. **27**

1. PLACE OF DEATH:

(a) County **CECIL**
(b) City or town **RURAL**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **2**
(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)

3. (a) PRINT FULL NAME **ERMA BEDFORD 316**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **George Bedford** 6. (c) Age of husband or wife if alive **44** years
7. Birth date of deceased **Feb - 1 - 1905**
(Month) (Day) (Year)

8. AGE: Years **35** Months **2** Days **16** If less than one day hr. min.

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

10. Usual occupation **housewife**

11. Industry or business

MOTHER FATHER { 12. Name **W.H. Bailey**
13. Birthplace **mo**
14. Maiden name **Netty Sheppard**
15. Birthplace **mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **George Bedford**

(b) Address **Eldorado Springs, mo**

17. (a) **Burial** (b) Date thereof **4-18-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sandridge (can)**

18. (a) Signature of funeral director **Wm. Siders**

(b) Address **Eldorado Springs, mo**

19. (a) **4/18/40** (b) **W.D. Dawson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **CECIL**
(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D. 2 Box Two**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **2** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **17**
year **1940** hour **7 a.m.** minute **7 a.m.**

21. I hereby certify that I attended the deceased from **May 1, 1939** to **April 17, 1940**
that I last saw **her** alive on **April 16**, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: **Septicemia**
Influenza
Lobar pneumonia
Duration **6 wks.**

Due to **Influenza**
Lobar pneumonia
Due to **Lobar pneumonia**

Other conditions **Lues**
(Include pregnancy within 3 months of death)

Major findings: **34**
Of operations **34**
Of autopsy **34**

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) **154**
(b) Date of occurrence **4/17/40**
(c) Where did injury occur? **While at work**
(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**
Means of injury **Wm. J. Tiller**
23. Signature **Wm. J. Tiller** (M. D. or other) **1**
Address **El Dorado Springs** Date signed **4/17/40**

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____

Registration District No. _____

1. USUAL RESIDENCE OF DECEASED

(a) State _____ (b) County _____

(c) City or town _____
(It exclude city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

2. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____

21. I hereby certify that I attended the deceased from _____ year _____ month _____ day _____

22. I last saw him _____ alive on _____ day _____ month _____ year _____

23. That death occurred on the date and hour stated above

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

3. STATEMENT BY LICENSED EMBALMER

(License holder's address & name of death)

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Working under my personal supervision.

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? _____

(d) Did injury occur in or about house or other building, place, or public place? _____

(e) Cause of death _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

4. ADDRESS

(a) Address _____

(b) Address _____

(c) Address _____

5. PLACE OF DEATH

(a) County _____

(b) City or town _____
(It exclude city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution _____

(d) Length of stay in hospital or institution _____
(Specify weeks)

(e) In this community _____

(f) Name of husband or wife _____

(g) Name of husband or wife _____

(h) Name of husband or wife _____

(i) Name of husband or wife _____

(j) Name of husband or wife _____

(k) Name of husband or wife _____

(l) Name of husband or wife _____

(m) Name of husband or wife _____

(n) Name of husband or wife _____

(o) Name of husband or wife _____

(p) Name of husband or wife _____

(q) Name of husband or wife _____

(r) Name of husband or wife _____

(s) Name of husband or wife _____

(t) Name of husband or wife _____

(u) Name of husband or wife _____

(v) Name of husband or wife _____

(w) Name of husband or wife _____

(x) Name of husband or wife _____

(y) Name of husband or wife _____

(z) Name of husband or wife _____

6. AGE

Years _____ Months _____ Days _____

7. Birth date of deceased

(Month) _____ (Day) _____ (Year) _____

8. Color or _____

9. Sex _____

10. Usual occupation _____

11. Industry or business _____

12. Burial place _____

13. Burial place _____

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100. Burial place _____

19. (a) Address _____

(b) Address _____

(c) Address _____

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(v) Address _____

(w) Address _____

(x) Address _____

(y) Address _____

(z) Address _____

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District 1-1-1
Officer 1-1-1

NUMBER 3-46-799
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH