

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MAY 9 1940

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

14760
Do not use this space.

1. PLACE OF DEATH

(a) County Waveress Registration District No. 249
(b) Township Salem Primary Registration District No. 5346
(c) City or St. _____
(d) Street No. _____
(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

Rachel Ann Egbert
(a) Residence, No. Pattonsburg, Mo. St. W. R. #3
(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 (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George Egbert (decd)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 31 - 1843

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
96 3 18

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. Housewife
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Henry Co Ind.

13. NAME Joseph Landes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

15. MAIDEN NAME Sophia Lord

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

17. INFORMANT (ADDRESS) Mrs. Roy Trimble
Pattonsburg Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Copsey Mo April 20, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. J. Brown
Pattonsburg Mo.

20. FILED April 23, 1940 Mrs. H. C. Cunningham
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 18, 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at 10:45 a.m.
The principal cause of death and related causes of importance were as follows:

Date of onset
Other contributory causes of importance:

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?
If so, specify _____
(Signed) _____, M. D.

(Address) _____

7 0019

RECEIVED
District Health Officer No. 11,
District File Number 240-617
Date Filed MAY 6 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 *Stromer*.....

Licensed Embalmer No. *2857*.....

P. O. Address *Davensburg 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

State File No. 14768

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 249

Primary Registration District No. 5346

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Daviess

(b) City or town Salmon, T.P.
(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..... (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Rachel Ann Egbert

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 wid

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 96 Months 3 Days 18 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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) April 23, 1940 (b) Mrs. H.A. Cunningham (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Daviess

(c) City or town Pattonburg, Rural #3
(If outside city or town limits write "RURAL")

(d) Street No. 4 miles S-W. of Coffey mo
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 18 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from April 22, 1940, to April 18, 1940; that I last saw him alive on April 16, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death General Failure of Vitality

Secondary to portneurosis

Due to Decay

Due to.....

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

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) (e) Means of injury.....

23. Signature J. G. Colson M.D. (M.D. or other)

Address Daviess mo Date signed Apr 18 1940

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-14760