

See also 15027-40
15028 Rev.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 379

Primary Registration District No. 4223-5521

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howard

(b) City or town R.F.D. # 2 Glasgow, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
At Home R.F.D. # 2 Glasgow, Mo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community Life (Specify whether _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard

(c) City or town R.F.D. # 2 Glasgow, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. # 2
(If rural, give location)

(e) If foreign born, how long in U. S. A. No life years.

3. (a) PRINT FULL NAME Mrs. Mabel May Kakey 240

3. (b) If veteran, name war. No 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 Thomas H. 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased February 19 1879
(Month) (Day) (Year)

8. AGE: Years 61 Months 2 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name William Lohr

18. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature X Thomas Kakey

(b) Address R.F.D. # 2 Glasgow, Mo.

17. (a) Burial (b) Date thereof May 2, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Cemetery

18. (a) Signature of funeral director L. J. Meister

(b) Address 300 N. 11th Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATE May 30 - 1940

20. DATE OF DEATH: Month May 3, 1940
year 1940 hour 4 minute 30 AM

21. I hereby certify that I attended the deceased from 4-26, 1940 to 5-1, 1940

that I last saw her alive on 4-26, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myo Carditis

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 22

(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? 24

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

23. Signature W. B. Mitchell (M. D. or other) _____
Address Palmyra Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39

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RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5/9/49

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 LeRoy Benz.....

Licensed Embalmer No. 4127.....

P. O. Address Marshall, 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.

Registration District No. 379

Primary Registration District No. 5529

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Chautauq J.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 _____ years, months or days)

3. (a) PRINT FULL NAME Mrs. Mabel May Lakey
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 m
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 61 Months 2 Days 11 If less than one day _____ 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 _____ (City, town, or county) _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. 5-2-40 (Date received local registrar) (b) [Signature] (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.

20. DATE OF DEATH Month apr day 20 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 _____

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 W. B. Kitchen (M. D. or other)
Address Blanton, Mo. Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PEN

