

MAY 15 1940

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

15031

Do not use this space.

1. PLACE OF DEATH
(a) County Newell 2 Registration District No. 387
(b) Township 0 Primary Registration District No. 554-0A
(c) City Monona, Mo (d) Street No. _____ Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.
2. PRINT FULL NAME Mary Ellen Baldwin
(a) Residence, No. 435 Mary Ellen Baldwin 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 fe 4. COLOR OR RACE whit 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m
- 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clarence E. Baldwin
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-10-1864
7. AGE YEARS 76 MONTHS 5 DAYS 12 If LESS than 1 day, hrs. or min.
- 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. 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 COUNTY) Illinois 1
- FATHER
13. NAME Geo. Butler 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois 1
- MOTHER
15. MAIDEN NAME Rebecca Atteberry
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
17. INFORMANT Clarence E. Baldwin
(ADDRESS) Monona, Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Newell Valley DATE 4-28 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wrest Plains, Mo
20. FILED 5-7 1940 Dora Coge Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-18 1940
22. I HEREBY CERTIFY, That I attended deceased from 3-14 1940 to 4-5 1940
I last saw him alive on 4-5 1940 Death is said to have occurred on the date stated above, at 9:00 p.m.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage Date of onset 3/14
- Other contributory causes of importance: none
- Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no
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) P. D. Gum, M. D.
(Address) West Plains, Mo.

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.

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.

RECEIVED
District Health Officer. No. 5,

Signed A. A. Robertson

District File Number 540572

Licensed Embalmer No. 3432

Date Filed 5/10/40

P. O. Address West Plains 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. 15031

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 387

Primary Registration District No. 5340A

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Iowa
(b) City or town Pomona
(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.
In this community (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME

Mary Ellen Baldwin

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..... years

7. Birth date of deceased Nov 6 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 12 If less than one day..... h..... 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)

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

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

(b) Address.....

1940 6-8 (Date received local registrar)

(b) Dora Cagle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 4 day 18 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..... 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.....

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).....

(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 P. D. Burn (M. D. or other)

Address West Plains Mo Date signed.....

SUPPLEMENTAL

