

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

AY 15 1940

Registration District No. 449

Primary Registration District No. 5618

1. PLACE OF DEATH: Laclede

(a) County Laclede

(b) City or town Dryden (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: No. Perryview Stare (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether years, months or days)

In this community 2 Mo. 2 da.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede

(c) City or town Dryden (If outside city or town limits, write "RURAL")

(d) Street No. No. Perryview Stare (If rural, give location)

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

3. (a) PRINT FULL NAME Marjorie Ewendine 253

3. (b) If veteran, name war None

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 27 year 1940 hour 7 minute 0 M.

4. Sex f 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 3 (Month) 17 (Day) 1920 (Year)

21. I hereby certify that I attended the deceased from April 26, 1940 to Apr. 27, 1940 that I last saw her alive on Apr. 26, 1940 and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months 2 Days 10 If less than one day _____ hr. _____ min.

Immediate cause of death Septicemia Duration 10 days

Due to infection from sore on mouth

Due to _____

9. Birthplace Labanon Laclede Co. Mo. (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 11518

10. Usual occupation None

11. Industry or business None

12. Name Green E. Ewendine

13. Birthplace Brownfield Mo. Laclede Co. (City, town, or county) (State or foreign country)

14. Maiden name Alta Rogers

15. Birthplace Labanon Mo. Laclede Co. (City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Green E. Ewendine

(b) Address Dryden Mo.

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

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

(b) Date of occurrence _____

17. (a) burial (b) Date thereof April - 28 - 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Cross Road

(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? _____

18. (a) Signature of funeral director J. B. P. Hall

(b) Address _____

19. (a) Apr 28 1940 (Date received local registrar)

(b) J. A. McCune (Registrar's signature)

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

28. Signature H. G. Hamilton (M. D. or other)

Address Labanon, Mo. Date signed 4-27-40

Rev. 5-17-30 1-10931

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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

RECEIVED

District Health Officer No. 7,

District File Number 5-40-814

Date Filed 5-8-48

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. 15-288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 449

Primary Registration District No. 5618

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Osage, Mo.
(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 years, months or days)

3. (a) PRINT FULL NAME Margaret EXEMDINE

3. (b) If veteran, name war _____

3. (c) Social Security No. 253

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 10 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-1-40 (b) Jamcoub
(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.

20. DATE OF DEATH: Month april day 27
year _____ 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 _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

