

FILED MAY 20 1940

S. No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15779
State File No.

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. 56

1. PLACE OF DEATH:

(a) County Phelps

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

(c) Name of hospital or institution:
Welfare Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days)

In this community 57-10-28 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps

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

(d) Street No. Raela Route 1
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs Anna Emerson

8. (b) If veteran, name war (c) Social Security No. 520

4. Sex F 5. Color or race wh 6. (a) Single, widowed, married, divorced married

(b) Name of husband or wife Wm B. Emerson 6. (c) Age of husband or wife if alive years

7. Birth date of deceased May 12 1882
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 18 If less than one day
hr. min.

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

10. Usual occupation housewife

11. Industry or business

12. Name Sam Emerson

13. Birthplace Phelps Mo
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Bailey

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

16. (a) Informant Wm B. Emerson

(b) Address Raela

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

(c) Place: burial or cremation accidental

18. (a) Signature of funeral director Rebecca

(b) Address Raela Mo

19. (a) May 2, 1940 (b) Joe F. Ayers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1940 hour 19 minute 00 A. M.

21. I hereby certify that I attended the deceased from Oct 19
1939 to April 30 1940
that I last saw her alive on April 30 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Atherosclerosis

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?
no
While at work? (Specify type of place)
(e) Means of injury _____

23. Signature Rebecca Bailey (M. D. or other) _____
Address Phelps Mo Date signed _____

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

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

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.....

RECEIVED

working under my personal supervision.

District Health Officer No. 5,

....., Registered Apprentice No.....

District File Number 540586

Signed.....

Date Filed 5/7/80

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.

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STANDARD CERTIFICATE OF DEATH

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 677

Primary Registration District No. 4403

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Rolla
(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)

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

Mrs Anna Tennessee

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

4. Sex 7 5. Color or race wh 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 May 12 1852
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 26 10 18 hr min.

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

10. Usual occupation

11. Industry or business

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) June 7, 1940 (b) Joe F. Ayers
(Obtained from local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 30
year hour minute M.

21. I hereby certify that I attended the deceased from 19..... to 19.....
that I 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

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 A Sidneyc Farland
Address Rolla Mo Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

5-15729