

AY 13 11

Registration District No. 689

Primary Registration District No. 3033

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pike
 (b) City or town Rensselaersville Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Pike Co. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Day (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike
 (c) City or town Rensselaersville
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 11
 year 1940 hour 12 minute 45 P. M.
 21. I hereby certify that I attended the deceased from 4-10-40
 _____, 19____, to 4-11-40, 19____

that I last saw her alive on 4-11-40, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to Stroke acute
 Due to _____

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

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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?
2-0

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature J. D. Cunningham (M. D. or _____)
 Address Rensselaersville Mo Date signed 4-11-40

3. (a) PRINT FULL NAME BEATRICE ODESSA SIMONS

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

4. Sex Female 5. Color or race Colored 6. (a) ~~Single~~ widowed married, divorced _____

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

7. Birth date of deceased 6 (Month) 4 (Day) 1931 (Year)

8. AGE: Years 18 Months 9 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name Daniel Jackson Watts
 13. Birthplace Eolia Mo
(City, town, or county) (State or foreign country?)

{ 14. Maiden name Sarah Elizabeth Thornton
 15. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fred Simons
 (b) Address Eolia Mo

17. (a) Burial (b) Date thereof Apr 14 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Eolia-Cal Cemetery

18. (a) Signature of funeral director Hooch & Live Co
 (b) Address Eolia Mo

19. (a) Apr 12 1940 (b) _____
(Date received local registrar) (Registrar's signature)

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 important. MAKE A PERMANENT RECORD

22

State Health Department

RECEIVED
District Health Officer No. 10
District File Number 5-40-950
Date Filed MAY 8 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 Norman E. Gooch
Licensed Embalmer No. 2342
P. O. Address Edalia, 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 15800

Registration District No. 689

Primary Registration District No. 3033

Registrar's No. _____

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

1. PLACE OF BIRTH:

(a) County Pike

(b) City or town Louisiana
(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 Beatrice Desarsimons

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color Cal 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. (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 18 Months 9 Days 7 If less than one year _____ 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) _____ (b) _____
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 11
year 1940 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 Tetanus
(acute)

Due to _____

Was spurred by rooster

Due to about 1 week before admission

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

Major findings: 22

Of operations _____

Of autopsy _____

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) accident

(b) Date of occurrence about 4/4/40

(c) Where did injury occur? Eolia Pike MO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
farm
(Specify type of place)

While at work? YES (e) Means of injury Rooster

23. Signature E. Cunningham (M.D. or other) MO

Address Louisiana Date signed _____

