

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15812

Registration District No. 688

Primary Registration District No. 5916

Registrar's No. 8

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Spencerburg
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) g
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Mary B Dowell 400
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Robert Dowell 6. (c) Age of husband or wife if alive 72 1/2 years
7. Birth date of deceased Apr. Oct 22 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 5 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business _____

12. Name Jeff Snedigar
13. Birthplace Ill
(City, town, or county) (State or foreign country)

14. Maiden name Mary Toxigen
15. Birthplace Dust to make Ill
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert Dowell
(b) Address Spencerburg MO

17. (a) Burial (b) Date thereof 4-14-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Spencerburg Cem

18. (a) Signature of funeral director Grace Blankhead
(b) Address Bowling Green, Mo

19. (a) May - 9 - 1948 Mathie Unsell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Pike
(c) City or town Spencerburg township
(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 12
year 1940 hour 3 minute _____ P. M.
21. I hereby certify that I attended the deceased from August
1939, to 4-12, 1940:
that I last saw her alive on 4-7, 1940:
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the uterus and rectum
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? 610
While at work? _____ (Specify type of place) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Bowling Green, Mo Date signed _____

Duration 3 yrs

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

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.

48

RECEIVED

District Health Officer No. 10

District File Number 5-40-2011

Date Filed MAY 10 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.....

Grace Banfhead

Registered Apprentice No.....

working under my personal supervision.

Signed Grace Banfhead

Licensed Embalmer No. 2204

P. O. Address Bowling Green 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. 158 12

Registration District No. 688

Primary Registration District No. 5916

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Rosette N.Y.
(b) City or town Rosette N.Y.
(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 _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 4 day 12
year 1970 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 Cancer of the uterus and rectum
primary
Due to Cancer of the uterus
primary

Other conditions _____
(Include pregnancy within 3 months of death) 48

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?

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

23. Signature T. A. Wilcoxon (M. D. or other)? _____
Bowling Green Date signed _____
ms

3. (a) PRINT FULL NAME Mary C. Donnell

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 ms

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 69 Months 6 Days 20 If less than one year _____ 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 _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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

ROULETTE
MAYBE
EAVES

SUPPLEMENTARY

