

MAY 15 1940

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

15835
Do not use this space.

1. PLACE OF DEATH

(a) County Bolt Registration District No. 701

(b) Township Marron Primary Registration District No. 5930

(c) City _____ (d) Street No. _____ St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jamie Geraldine McInnis

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15 - 1940

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

9 0 13

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.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 29 1940

22. I HEREBY CERTIFY, That I attended deceased from Apr 21 1940 to Apr 28 1940

I last saw her alive on 4-28 1940. Death is said to have occurred on the date stated above, at 9:00 A.M.

The principal cause of death and related causes of importance were as follows:

Miliary Tuberculosis

Confirmed by Tuberculin test & X-ray chest

Other contributory causes of importance:

Date of onset 6 wks ago

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____

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? no

If so, specify _____

(Signed) D. C. McInnis, M. D.

630 (Address) Bolivar Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bolt Mo

13. NAME Jim McInnis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Bella Spinks

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adrian Mo

17. INFORMANT (ADDRESS) Jim McInnis

18. BURIAL, CREMATION, OR REMOVAL PLACE Graves DATE Apr 29 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hutchins

20. FILED 4-29 1940 J. F. Roberts Local Registrar.

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.

RECEIVED
District Health Officer No. 74
License File Number 5-40-798
Date Filed 5-7-40

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. 15-835-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 701

Primary Registration District No. 2930

Registrar's No. 21

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

1. PLACE OF DEATH:

(a) County Polk Co
(b) City or town Marion T.P.
(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 Janice Geraldene Mc Ginnis

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.....

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

7. Birth date of deceased July 15 - - 1939
(Month) (Day)

8. AGE: Years Months Days If less than 1 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) 4-30 (b) of J. A. Roberts
(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 29
year 1970 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.....

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 J. C. McLean (M. D. or other)
Address Bolivar Mo Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

PL

14