

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

18547

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Windsor
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 28 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Katherine Heary

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased unknown 1845
(Month) (Day) (Year)

8. AGE: Years 94 Months _____ Days _____ If less than one day hr. _____ min.

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

10. Usual occupation at home

11. Industry or business

12. Name Joseph Shupe
13. Birthplace unknown Pa.
(City, town, or county) (State or foreign country)

14. Maiden name unknown
15. Birthplace unknown unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Will Lindsey
(b) Address Windsor, Missouri

17. (a) Burial (b) Date thereof May 21-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation High Point Cemetery Johnson County, Mo.

18. (a) Signature of funeral director Huston Turner
(b) Address Windsor, Missouri

19. (a) 5-21-46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Windsor
(If outside city or town limits, write "RURAL")
(d) Street No. 404 S. Franklin
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19
year 1940 hour 19 minute 8 M.

21. I hereby certify that I attended the deceased from May 10, 1940, to May 19, 1940
that I last saw her alive on May 19, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure Duration _____

Due to Uremia

Due to arteriosclerosis

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? 319

(Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) D.O.
Address Windsor, Mo. Date signed May 20

RECEIVED
District Health Officer No. 7
District File Number 6-40-890
Date Filed 6-18-40

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.