

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.

1940 APR 14 1940

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

18883
Do not use this space.

1. PLACE OF DEATH

(a) County Lewis Registration District No. 480
 (b) Township 0 Primary Registration District No. 4289
 (c) City La Grange (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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.

Registered No. 12

2. PRINT FULL NAME

420 Eliza Calsaw
 (a) Residence, No. La Grange, Mo. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 11th. 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 2 18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home

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

12. BIRTHPLACE (CITY OR TOWN) Dallas (STATE OR COUNTRY) Texas

13. NAME Ben Dade

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

15. MAIDEN NAME Lucy Downing

16. BIRTHPLACE (CITY OR TOWN) unknown (STATE OR COUNTRY)

17. INFORMANT Jollie Douglass (ADDRESS) La Grange, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE La Grange, Mo. DATE May 1st. 1940

19. FUNERAL DIRECTOR (NAME) M. O. Oakes (ADDRESS) La Grange, Mo.

20. FILED May 1 1940 W. B. Easley Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from APRIL 21 1940 to APRIL 29 1940

I last saw her alive on APRIL 29 1940 Death is said to have occurred on the date stated above, at 5:40 am.

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

HEMORRHAGE OF LUNG

Date of onset APR 26/40

Other contributory causes of importance: MITRAL REGURGITATION

Name of operation Date of
 What test confirmed diagnosis? CHEMICAL Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 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) W. B. Easley M. D.
 (Address) La Grange, Mo.
133

922

RECEIVED

District Health Officer No. 10

District File Number 6-40-1147

Date Filed JUN 7 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,

A.A. Roberts

, or by

Registered Apprentice No. _____, working under my personal supervision.

Signed A.A. Roberts

Licensed Embalmer No. 1626

P. O. Address La Grange, 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

State File No. 18893

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 480

Primary Registration District No. 4289

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town La Grange
(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 Eliza Galsaw

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

4. Sex 7 5. Color or race Col 6. (a) Single, widowed, married, divorced wid

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 76 Months 2 Days 18 If less than one day _____ 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10/1/40 (b) W L Allen (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 Apr day 29 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that last saw him _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death Memorandum of CONGESTION

Due to _____

Due to _____ Other conditions mitral Regurgitation (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 926

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) _____
(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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-18883