ENTERED JUN 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

19253

State File No.

Registration District No. 688. Primary Registration District No. 4412 Registrar's No. 10

1. PLACE OF DEATH:
(a) County PIKE
(b) City or town FRANK FORD MO
(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
In this community ENTIRE LIFE (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County PIKE
(c) City or town FRANKFORD MO
(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.

3. (a) PRINT FULL NAME WILLIAM THOMAS CASH
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife LOUISE CASH
6. (c) Age of husband or wife if alive years
7. Birth date of deceased FEBRUARY (Month) 13 (Day) 1866 (Year)
8. AGE: Years 74 Months Days 29 If less than one day hr. min.
9. Birthplace PIKE CO (City, town, or county) MO (State or foreign country)
10. Usual occupation FARMER
11. Industry or business
FATHER 12. Name JOHN CASH
13. Birthplace (City, town, or county) MO (State or foreign country)
MOTHER 14. Maiden name VIRGINIA WADDELL
15. Birthplace (City, town, or county) MO (State or foreign country)
16. (a) Informant's own signature Frank Cash
(b) Address Frankford Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 14-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Frankford Mo
18. (a) Signature of funeral director W. H. Suda
(b) Address Louisiana Mo
19. (a) May 14-1940 (Date received local registrar) (b) Mattie Unsell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 12 year 1940 hour 3:00 minute P.M.
21. I hereby certify that I attended the deceased from Nov. 7 1939, 19__, to May 12, 1940; that I last saw him alive on May 12, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate gland and bladder — Duration

Due to

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

23. Signature O. W. Bridgman (M. D.)
Address Frankford Mo Date signed 5/14/40

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 I X19511

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

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.

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RECEIVED
District Health Officer No. 10
District File Number 6-40-1140
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, or by Harold Garner, Registered Apprentice No. ....., working under my personal supervision.

Signed Harold Garner

Licensed Embalmer No. 3720

P. O. Address Louisiana 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.

S. No. 2B
M—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1925-3

Registration District No. 688 Primary Registration District No. 4412 Registrar's No.

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

ROWENA MOORE

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Frankford
(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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME Wm Thomas Cash
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced wd
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 74 Months 2 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12 year 1940 hour 1 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 Prostate gland and bladder — Duration
Due to It originated in prostate gland
Due to
Other conditions
(Include pregnancy within 3 months of death) 51
Major findings:
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)
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature O. W. Snodgrass (M. D. or other)
Address Frankford Mo. Date signed

SUPPLEMENTARY

S-19253