DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUL 15 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22455

Registration District No. 921 Primary Registration District No. 5 8 5 4 Registrar's No.

1. PLACE OF DEATH:

(a) County Ozark Bi[illegible]

(b) City ~~or town~~ Ocil

(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ozark

(c) City or town Ocil

(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 M. Frances Tannehill

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar (Month) 5 (Day) 1863 (Year)

8. AGE: Years 77 Months 1 Days 27 If less than one day hr. min.

9. Birthplace Howell Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name William J. Adams
13. Birthplace — (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Sarah Herrin
15. Birthplace — (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant's own signature J M Rozell

(b) Address Protem

17. (a) (Burial, ~~cremation, or removal~~) (b) Date thereof 5/3/40 (Month) (Day) (Year)

(c) Place: burial or cremation Protem

18. (a) Signature of funeral director O. B. McClure

(b) Address Mt Home Ark

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2 year 1940 hour 3 minute 20 A. M.

21. I hereby certify that I attended the deceased from no medical aid, 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Stroke about 6 Hours	
Due to	
Due to 92	
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 Mary F. Johnson (M. D. or other) L R

Address Theodosia Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.

1 X19511

RECEIVED
District Health Officer No. 6,
District File Number 740-2309
Date Filed JUL 8 1940 JUL 8 1940

JUL 8 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.....

....., 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 comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

2B
-40
22659

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22455

Registration District No. 920 Primary Registration District No. 3858 Registrar's No.

1. PLACE OF DEATH:

(a) County: Ozark

(b) City or town: Big Creek (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: Mary Francis Tannehill

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

4. Sex: F 5. Color or race: W 6. (a) Single, widowed, married, divorced: m

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: 77 Months: 1 Days: 27 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)

18. Place: burial or cremation

19. (a) Signature of funeral director

(b) Address

20. (a) June 15 1940 (Date received local registrar) Mary F. Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2 year 1940 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 — 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: Mary F. Johnson (M.D. or other)

Address: Theodosia Date signed

SUPPLEMENTARY