

Registration District No. 842 Primary Registration District No. 204 4512 Registrar's No.

1. PLACE OF DEATH:

(a) County Stone

(b) City or town Crane
(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 Missouri (b) County Stone

(c) City or town Crane
(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 Susan Laura Iddings 352

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 Chas. Rollin Iddings

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

7. Birth date of deceased Aug. 4, 1854
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
85	10	26	hr. min.

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

10. Usual occupation At Home

11. Industry or business Housewife

12. Name John Mumma

13. Birthplace Don't Know
(City, town, or county) (State or foreign country)

14. Maiden name Frances Sheppe

15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. W. Bingham

(b) Address 1011 7th. St., Monett, Mo.

17. (a) Burial (b) Date thereof July 3, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation I. O. O. F. Cemetery

18. (a) Signature of funeral director Calloway Funeral

(b) Address Monett Mo

19. (a) June 30 - 1940 (b) Mrs. Ethel Duggitt
(Received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30 year 1940 hour 7:06 minute P. M.

21. I hereby certify that I attended the deceased from April 6, 1940 to June 30, 1940 and that death occurred on the date and hour stated above.

that I last saw h. er. alive on June 30, 1940

Immediate cause of death Bands Pneumonia Duration 6-28-40

Due to Fracture Left Hip 5-6-40

Due to Infermities of Age

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? 766

(e) Signature A. P. Carter MD (M. D. or other) _____

Address Crane, Mo. Date signed 6-28-40

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

RECEIVED

District Health Officer No: 6,

District File Number 740-2380

Date Filed JUL 12 1940 JUL 12 1940

JUL 12 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 _____

my self
working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. 20660

P. O. Address monett 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. **22987**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **847**

Primary Registration District No. **4512**

Registrar's No. _____

R

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

1. PLACE OF DEATH

(a) County **Stone**
(b) City or town **Crane**
(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) (Specify whether

3. (a) PRINT FULL NAME

Susan Laura Adams

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 **wid**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year _____ min.

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

8. AGE: Years **85** Months **10** Days **26** 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) _____ (b) _____ (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 **June** day **30**
year **1970** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Broncho Pneumonia

Due to **Fracture of left**

Due to **hip**

infinitis of age

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations **196W**

Of autopsy **18**

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) **Accident**

(b) Date of occurrence **April 9, 1970**

(c) Where did injury occur? **Crane Store, Mo.** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Fall in home**

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

23. Signature **G. P. Cappetta M.D.** (M. D. or other)

Address **Crane** Date signed _____

SUPPLEMENTAL

S-22987