

FILED AUG 16 1939

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

25554

Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 448
 (b) Township 2 Primary Registration District No. 5-608 Registered No. 12
 (c) City _____ (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred life (If death occurred in Hospital or Institution, write its name instead of street and number)
 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

536 Abbie Pender
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Tom Pender</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>October 16, 1860</u>		
7. AGE	YEARS <u>78</u>	MONTHS <u>7</u>
	DAYS <u>4</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Home</u>	
	10. Date deceased last worked at this occupation (month and year) <u>1939</u>	
	11. Total time (years) spent in this occupation <u>life</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Iowa</u> /		
FATHER	13. NAME <u>Bill Porter</u> /	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Iowa</u> /	
MOTHER	15. MAIDEN NAME <u>Catherine Puckett</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Iowa</u>	
17. INFORMANT (ADDRESS) <u>Mrs. Rhoda Webb</u> <u>Midland, Texas</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Conway</u> DATE <u>May 21, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Rex Rainey</u>		
20. FILED <u>8-10</u> 19 <u>40</u> <u>ARA. Montgomery</u> <u>Local Registrar</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>May 20, 1939</u>
22. I HEREBY CERTIFY, That I attended deceased from <u>5-18</u> , 19 <u>39</u> , to <u>5-20</u> , 19 <u>39</u> I last saw <u>her</u> alive on <u>5-20</u> , 19 <u>39</u> Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows: <u>Acute Illus Cellitis</u> Date of onset _____ Other contributory causes of importance: <u>12/13</u>
Name of operation _____ Date of _____ What test confirmed diagnosis? _____ Was there an autopsy? _____
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? <u>No</u> If so, specify _____ (Signed) <u>J. W. Lindsay</u> , M. D. <u>Conway</u>

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED

District Health Officer No. 7,
District File Number 8-40-1212
Date filed 8-14-10

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.