

Registration District No. 535

Primary Registration District No. 5719

1. PLACE OF DEATH:

(a) County Leaon
 (b) City or town Excello (Rural) Middle Fork
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Five miles east Excello
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. (Specify whether)
Unknown
 In this community _____ years, months or days

3. (a) PRINT FULL NAME Alta Pearl Cavanaugh. 152

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife John Cavanaugh 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased: August 5, 1910
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	29	10	16	hr. min.

9. Birthplace Leaon County Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Virgil Snodgrass

13. Birthplace Leaon County Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Rosa Summers

15. Birthplace Leaon Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Cavanaugh

(b) Address Excello, Missouri.

17. (a) burial (b) Date thereof 7/8/40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethlehem Cemetery.

18. (a) Signature of funeral director Albert Skinner.

(b) Address Leaon Mo.

19. Aug 9, 1940 (b) Gela King
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Leaon
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Five miles east of Excello
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
 year 1940 hour 10:00 P. Minute _____ M.

21. I hereby certify that I attended the deceased from Dec 13 1939 to July 6 1940
 that I last saw her alive on July 6 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Adamsia

Due to Pregnancy 9 mo

Other conditions Pregnancy Term
 (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? _____

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

23. Signature J F Turner (M. D. or other)
 Address Leaon Mo. Date signed 7/24/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

146
RECEIVED

District Health Officer No. 10

District File Number X-40-1528-

Date Filed AUG 8 1943

Dr. Turner

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

George Phile

Licensed Embalmer No. 4866

P. O. Address Macon, Ga.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 25-687

Registration District No. 235-

Primary Registration District No. 2719

Registrar's No. _____

1. PLACE OF DEATH:

(a) County macon
(b) City or town middle town
(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 _____ (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

Alta Pearl Cavanaugh

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race W

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

6. (b) Name of husband or wife _____

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

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

8. AGE:

Years 29 Months 10 Days 16

If less than one day _____ hr _____ 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 _____
(Burial, cremation, or removal) (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)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH _____ month _____ day _____
_____ year _____ 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 Pregnancy
Eclampsia
Due to _____ 146
Due to _____

Other conditions (Include pregnancy within 3 months of death) Pregnancy
Major findings: Normal delivery
about four hours
before death
Of autops _____

Duration
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 J. F. Turner (M. D. or other) _____
Address Macon, Mo Date signed 8/14/40

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

SUPPLEMENTAL

