

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

Do not use this space.

26167

1. PLACE OF DEATH

County Hodgdon Registration District No. 839  
Township Reardan Primary Registration District No. 4570  
City Emery (No. ....) (State ..... Ward)

File No. ....  
Registered No. 19 .....

2. FULL NAME

Stella Brennan (BISMAN)  
(a) Residence, No. Essex Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hubert  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 9, 1893  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
47 2 24

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.   
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation. ....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER  
13. NAME J. Dillard

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER  
15. MAIDEN NAME Elizabeth Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Tracy J. Borden Emery Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Emery DATE 7/5 40

19. UNDERTAKER (ADDRESS) Blaugher Ship 75th St. Emery Mo.

20. FILED 7-4-40 80 Brennan Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 3 1940

22. I HEREBY CERTIFY, That I attended deceased from Apr 25 1940, to July 3 1940  
I last saw him alive on July 3 1940 Death is said to have occurred on the date stated above, at 9 P. m.

The principal cause of death and related causes of importance were as follows:

Cancer Breast Date of onset

Other contributory causes of importance:

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? .....

If so, specify gtd. Met. Emery

(Signed) gtd. Met. Emery M. D.

(Address) Emery

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.

THIS IS A PERMANENT RECORD

1-2724

5D

RECEIVED

District Health Officer No. 2

District File Number 840-137

Date Filed 8/20/60

(c)  
 (b)  
 In  
 (a) 2  
 (b) 3  
 (c) 4  
 (d) 5  
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 (q) 18  
 (r) 19  
 (s) 20

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **26467**

Registration District No. **839**

Primary Registration District No. **4870**

Registrar's No. \_\_\_\_\_

1. PLACE OF BIRTH:  
(a) County **Stoddard**  
(b) City or town **Casey**  
(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)  
Length of stay: In hospital or institution \_\_\_\_\_  
in this community \_\_\_\_\_ (Specify whether \_\_\_\_\_, 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.

PRINT FULL NAME **Stella Beeman**  
(b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

19. MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **July** day **3**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex **7** 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 \_\_\_\_\_ years

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 **Cancer Breast** Duration \_\_\_\_\_

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
AGE: Years **47** Months **2** Days **24** If less than one day \_\_\_\_\_ min. \_\_\_\_\_

Due to **retum** **50**  
Due to **Primary Source**  
Other conditions (Include pregnancy within 3 months of death) **Breast**

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)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) \_\_\_\_\_  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **[Signature]** (M. D. or other) \_\_\_\_\_  
Address **[Address]** Date signed \_\_\_\_\_

SUPPLEMENTARY

RECORD

MOTHER FATHER

