

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

26468

Registration District No. 839

Primary Registration District No. 4570

Registrar's No. 20

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Essay
(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 Mo (b) County Stoddard
(c) City or town Essay, Mo.
(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 G. Whitehead
(b) If veteran, name war ✓ (c) Social Security No. ✓
4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife deceased 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased May 12 - 1845
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 30 day July
year 1940 - hour 10:25 minutes PM
21. I hereby certify that I attended the deceased from one
visit 7-19, 1940, to _____, 19____;
that I last saw her alive on 7-29, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years 95 Months 2 Days 18 If less than one day _____ hr. _____ min.
9. Birthplace Ky. (City, town, or county) (State or foreign country)
10. Usual occupation room
11. Industry or business _____
12. Name Dart Know
13. Birthplace Dart Know (City, town, or county) (State or foreign country)
14. Maiden name Dart Know
15. Birthplace Dart Know (City, town, or county) (State or foreign country)

Immediate cause of death Senility
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____
Duration 19

16. (a) Informant's own signature Therett Denton
(b) Address Essay Mo
17. (a) County Auditor (b) Date thereof 7-31-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Co. Deer
18. (a) Signature of funeral director none
(b) Address 7511
19. (a) 7-31-40 (b) J. P. Decker
(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 J. P. Decker (M. D. or other) _____
Address Essay, Mo. Date signed 7-31-40

WHIRIE 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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

RECEIVED

District Health Officer No. 2

District File Number 840-137

Date Filed 8/20/40

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.