

3 1940

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

26561
Do not use this space.

1. PLACE OF DEATH ²

(a) County Wayne Registration District No. 891

(b) Township Benton ⁵ Primary Registration District No. 4540 Registered No. 17

(c) City Piedmont (d) Street No. _____ St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ¹⁶³ Tracie May Deboard

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, give county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 27-40

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

6 2

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child

9. Industry or business in which work was done, as 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) Iron County Mo.

13. NAME Thomas W. Deboard

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iron Co. Mo.

15. MAIDEN NAME May Hessler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co. Mo.

17. INFORMANT (ADDRESS) Emmett Womach Piedmont, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Cemetery DATE July 30, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) William Baker Piedmont, Mo.

20. FILED 7-30 1940 W. C. Piles, M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 29, 1940

22. I HEREBY CERTIFY That attended deceased from 7-27-1940 to 7-29-1940

I last saw her alive on 7-28-, 1940 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:

Chloroform poisoning

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? See

If so, specify _____

(Signed) W. C. Piles M. D. (Address) Piedmont, Mo.

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.

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.....

Coder Funeral Home....., Registered Apprentice No.....
working under my personal supervision.

Signed *William Coder*.....

Licensed Embalmer No. *3723*

P. O. Address *Bedmont 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. **265-61**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **891**

Primary Registration District No. **4540**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Wayne**
(b) City or town **Piedmont**
(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)

3. (a) PRINT FULL NAME

Gracie May Deboard

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 **8**
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 2 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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 **William Coder**

(b) Address **Piedmont, Missouri**

19. (a) **7-23-1944** (b) **T. O. Jones M.D.** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Wayne**
(c) City or town **Piedmont**
(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.

DEATH CERTIFICATION

20. DATE OF DEATH Month **July** day **29**
year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

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?

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

23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

