

7-39
X21492

Registration District No. 2379

Primary Registration District No. 4351

Registrar's No.

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town New Florence Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 Months years, months or days

3. (a) PRINT FULL NAME Joanna Rice 207

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 26 th 1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 6 If less than one day hr. _____ min.

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

10. Usual occupation Home

11. Industry or business _____

12. Name Robinson Farmer

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

14. Maiden name Neoma Foster

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

16. (a) Informant Oliver Johnson
(b) Address New Florence Mo

17. (a) Burial (b) Date thereof 9/3/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Florence Cem

18. (a) Signature of funeral director C. W. Hopkins
(b) Address Montgomery City Mo

19. (a) 9-9-40 (b) James O. Helm, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery
(c) City or town New Florence
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9/2/40 day 12:05 am
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 31, 1940 19 _____ to Sept. 2, 1940 19 _____

that I last saw h. _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis of respiratory center 3 days

Due to _____

Due to _____

Other conditions Hemiplegia, right.
(Include pregnancy within 3 months of death)

Arterio sclerosis

Major findings: Of operations _____

Of autopsy _____

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? _____

523

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Shull Mendenhall (M. D. or other) _____

Address Montgomery City Date signed 9-3-40

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

828

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 _____ on the _____
day of Sept 1940 _____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. 1487

P. O. Address Montgomery City 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.

2B
2-21-40
X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29106

Registration District No. 593

Primary Registration District No. 4357

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Montgomery

(b) City or town New Florence
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Joanna Rice

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 wid

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	Months	Days	If less than one day
	<u>76</u>	<u>9</u>	<u>6</u>	_____ 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)

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.

20. DATE OF DEATH: Month 9 day 2
year 1940 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 Paralysis of respiratory center

Due to _____

Due to _____

Other conditions Hemiplegia, right
(Include any within 3 months of death)

Major findings: arteriosclerosis
Cerebral haemorrhage

Of operations _____

Of autopsy _____

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 Bull (M. D. or other) _____

Address Montgomery Date signed 10 24 40

SUPPLEMENTARY

PHYSICIAN

Duration 3 days

Underline the cause to which death should be charged statistically.

