

SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29436

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 177

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly

(c) Name of hospital or institution: McBarnick Hospital
(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 Etta M Priest 623

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: Jan 2nd 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>7</u>	<u>25</u>	hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____

12. Name John B. Colam 13. Birthplace Ill
(City, town, or county) (State or foreign country)

14. Maiden name Addie Fagan 15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant J. Duncan Major

(b) Address De Moines Iowa

17. (a) Burial (b) Date thereof Aug 29 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Monroe City, Mo

18. (a) Signature of funeral director Malran and Son
(b) Address Moberly Mo

19. (a) Aug 29-40 (b) Seale Hildebrand
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Moberly, Mo
(If outside city or town limit, write "RURAL")

(d) Street No. W. Reed St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27th
year 1940 hour 1 minute 0 M.

21. I hereby certify that I attended the deceased from 4-22
1940, to Aug-27, 1940,
that I last saw her alive on Aug 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of bowel & bladder

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

Duration 1 yr.

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? 9-5
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature A. L. McCormick (M. D. or other) 1
Address Moberly Mo Date signed _____

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

3018

17-39
X21492

46

RECEIVED

District Health Officer No. 10

District File Number 9-40-1825

Date Filed SEP 18 1940

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 Frank D. DeWitt

Licensed Embalmer No. 3021

P. O. Address Mobile

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. **29436**
Registrar's No. **177**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **735-**

Primary Registration District **3034**

HOWARD MOORE

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

1. PLACE OF DEATH:

(a) County **Randolph**
(b) City or town **Moberly**
(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)

3. (a) PRINT FULL NAME

Etta M. Priest

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 **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 _____

69

7

25

_____ 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) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____

(Date received local registrar)

(b) _____

(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **27**
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: **Carcinoma of the**

uterus

Due to **Carcinoma of the uterus**

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) **48**

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?

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

23. Signature **F. L. McCarmon**

Address **Moberly Mo** Date signed _____

SUPPLEMENTAL

