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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 24 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30013

Registration District No. 887

Primary Registration District No. 4185

Registrar's No.

1. PLACE OF DEATH:

(a) County Washington
(b) City or town St. Charles
(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 2
In this community 270
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Washington
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Rebecca Rodrick

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 ✓

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

7. Birth date of deceased Jan 7 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 6 19 hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Gene Lachand

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

14. Maiden name Patricia Seymour

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

16. (a) Informant Joe Rodrick

(b) Address Richwoods, MO

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof July 24 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Richwoods

18. (a) Signature of funeral director Sparks

(b) Address Palace mo

(a) (Date received local registrar) _____ (b) D W Parker
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22 1940
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 1938
7-22, 1940, to _____, 1940
that I last saw her alive on 7-17, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Hemorrhage Duration _____

Due to _____
Due to _____

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

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? 807
While at work? _____ (Specify type of place) Means of injury _____

23. Signature D W Parker (M. D. or other) 1

Address Richwoods Date signed 23

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

224

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 complete 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. **30013**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **889**

Primary Registration District No. **8185**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Washington**
(b) City or town **Richards T. P.**
(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.
In this community, years, months or days (Specify whether)

3. (a) PRINT FULL NAME

Rosanna Roderick

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

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 **80** Months **6** Days **9** If less than one day, 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 (City, town, or county) (State or foreign country)

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

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) **W. Parker** (Registrar's signature)

(Date received local registrar) (Date signed)

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 **July** day **22** 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, and that death occurred on the date and hour stated above.

Immediate cause of death **Cranial Hemorrhage**

Due to **Pressure in Cavity**

Due to **Stroke**

Other conditions **arterio sclerosis** (Include pregnancy within 3 months of death)

Major findings: Of operations **820**

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 **W. Parker** (M. D. or other)

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

