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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
OCT 23 1940

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 31248

Registration District No. 1 | Primary Registration District No. ~~2~~ 1 | Registrar's No. 231

**1. PLACE OF DEATH:**

1 (a) County Adair

2 (b) City or town Kirksville (If outside city or town limits, write "RURAL" and name of township)

2 (c) Name of hospital or institution: N. Luther (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Adair

(c) City or town Kirksville (If outside city or town limits, write "RURAL")

0 (d) Street No. N. Luther (If rural, give location)

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

3. (a) PRINT FULL NAME ANNA. PARCEL

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 W

6. (b) Name of husband or wife Mont Parcel | 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased May (Month) 22 (Day) 1863 (Year)

8. AGE: Years 77 | Months 4 | Days 9 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Hwy. 9

11. Industry or business 9

FATHER
12. Name Unk
13. Birthplace " (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name "
15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant Anna Day

(b) Address Kirksville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Llewellyn

18. (a) Signature of funeral director Summers + Fleischgang

(b) Address

19. (a) Oct. 5/40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

D2 4 [illegible]

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 1 year 1940 hour 7 A.M. minute ..... M.

21. I hereby certify that I attended the deceased from Sep 31, 1940 to Sep 31, 1940; that I last saw her alive on Sep 31, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Disease Chronic myocarditis

Due to Hex Sclerosis

Due to " "

Other conditions (Include pregnancy within 3 months of death) 9 2 C

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? (Specify type of place)

3 While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) 1

Address [illegible] Date signed Oct 2 40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-40-2009
Date Filed OCT 24 1940

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**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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**