

31262

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED OCT 23 1940

Registration District No. 13

Primary Registration District No. 4010

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Andrew,  
 (b) City or town Savannah  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Dr. Nichols Sanitorium,  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 20 days,  
 (Specify whether  
 In this community 20 days,  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas, (b) County Woodson,  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. R. F. D. # 2, Gridley, Kansas,  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Alice Holmes,  
 3. (b) If veteran, name war None, 3. (c) Social Security No. None,  
 4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife John R. Holmes, 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased December 2, 1873  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept day 4  
 year 1940 hour 5 minute A M.  
 21. I hereby certify that I attended the deceased from Aug 15  
 \_\_\_\_\_, 1940, to Sept 4 1940, 19\_\_\_\_;  
 that I last saw her alive on Sept 4 1940, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute spasmodic Asthma  
 Duration 10da  
 Due to Carcinoma right breast and axilla  
6 mo.

8. AGE: Years Months Days If less than one day  
66 9 2 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

9. Birthplace Toronto, Kansas,  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation At Home,  
 11. Industry or business \_\_\_\_\_  
 12. Name Gill Brazal,  
 13. Birthplace Unknown,  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown,  
 15. Birthplace Unknown,  
 (City, town, or county) (State or foreign country)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

16. (a) Informant's own signature John R. Holmes  
 (b) Address R. F. D. # 2, Gridley, Kansas,  
 17. (a) Removal (b) Date thereof 9/11/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Gridley, Kansas  
 18. (a) Signature of funeral director Frank H. Baum  
 (b) Address Savannah, Mo.  
 19. (a) Sept 5-40 (b) Mrs. Jennie Rash  
 (Date received local registrar) (Registrar's signature)

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)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address Savannah, Mo Date signed 9/14/40

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

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

Rev. 5-17-39  
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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 Sept. 4-40

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Wm E. Summerfield

Licensed Embalmer No. 2007

P. O. Address 319 So. St. Joseph

**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.**

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

1. PLACE OF DEATH:

(a) County: Andrew  
(b) City or town: Savannah  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

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.

3. (a) PRINT FULL NAME: Alice Holmes

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: m

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 66 Months 9 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ 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) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month Sept day 4  
year 1970 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: Acute spasmodic asthma

Due to: Carcinoma, right breast and apilla  
Due to: The Primary site of malignancy was right breast

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature: [Signature] (M. D. or other) \_\_\_\_\_

Address: Savannah, Ga Date signed \_\_\_\_\_

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

