

OCT 12 1940

89

Primary Registration District No. 3007

Registration District No. 89

1. PLACE OF DEATH:

(a) County BUTLER
(b) City or town POPLAR BLUFF
(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 CLAUDIA BERNICE RONE

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 married
6. (b) Name of husband or wife Irwin Rone 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 19 1920 (Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 28 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Elizabeth McHenry 9
18. Birthplace _____ (City, town, or county) (State or foreign country) unknown
14. Maiden name _____ (City, town, or county) (State or foreign country) unknown
15. Birthplace _____ (City, town, or county) (State or foreign country) unknown

16. (a) Informant's own signature J. B. Rone

(b) Address Poplar Bluff Mo

17. (a) Burial (b) Date there Sept 20 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director NT Phelps

(b) Address Poplar Bluff Mo

19. (a) 9-24-40 (b) Adelbertinger (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler
(c) City or town Poplar Bluff Mo (If outside city or town limits, write "RURAL")
(d) Street No. 523 Pine St (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17 year 1940 hour 11 minute 20 P. M.

21. I hereby certify that I attended the deceased from July 11 1940 to Sept 17 1940 and that death occurred on the date and hour stated above.
that I last saw her alive on Sept 15 1940

Immediate cause of death Pulmonary hemorrhage Duration 1 day
Due to Arteriosclerosis ?

Due to Hypertension 6 mo

Other conditions (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? _____

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

23. Signature J. B. Rone (M. D. or other) _____
Address Poplar Bluff Mo Date signed 9/18/40

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.

23

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. ~~3227~~

working under my personal supervision.

Signed..... *A. J. Phelps*

Licensed Embalmer No. *3231*

P. O. Address..... *Paplan Bleeffine*

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. 31576

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 89

Primary Registration District No. 3007

Registrar's No. 284

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

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Osage Bluff
(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

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 Claudia Bernice Rone

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 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 Months Days If less than one day min.
60 0 28

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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. (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

20. DATE OF DEATH Month Sept day 17 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 Pulmonary embolism

Due arterio sclerosis

Due hypertension

Other conditions No tuberculosis!

Major findings: A. M. D.

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 J. L. Kuehler (M. D.) or other _____

Address Osage Bluff, Mo. Date signed 11/18/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

