

FILED OCT 23 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31867

State File No.

Registration District No. 247Primary Registration District No. 5342Registrar's No. 18

1. PLACE OF DEATH

(a) County Dallas
(b) City or town Rt. 2, Conway, Mo
(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 2
(Specify whetherIn this community nine months
years, months or days8. (a) PRINT FULL NAME Nova May St. Clair

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex F.M. 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife O.J. St. Clair 6. (c) Age of husband or wife if alive 47 years7. Birth date of deceased May 13 1899
(Month) (Day) (Year)8. AGE: Years 41 Months 2 Days 23 If less than one day hr. min.9. Birthplace Tennessee
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

12. Name Major Jenkins13. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Nova May Hendren
(City, town, or county) (State or foreign country)15. Birthplace Tennessee
(City, town, or county) (State or foreign country)16. (a) Informant O.J. St. Clair(b) Address Rt. 2, Conway, Mo.17. (a) Burial (b) Date thereof Aug 3-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Green Mountain

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct 12 (b) Dr. J. W. Lindsey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas(c) City or town Rt. 2, Conway, Mo.
(If outside city or town limits, write "RURAL")(d) Street No. 0
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2
year 1940 hour 3 minute --- M.21. I hereby certify that I attended the deceased from 6-2-40
to 8-2, 1940 to _____, 19---
that I last saw her alive on 7-25, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary T.B.

Due to _____

Due to _____

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? _____

White at work? _____ (Specify type of place)
(e) Means of injury _____23. Signature J. W. Lindsey (M. D. or other) _____Address Conway Date signed 8-4-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7

District File Number 10-40-1503

Date Filed 10-17-40

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

Hayd W. Fox

Licensed Embalmer No.

7910

P. O. Address

679 W. Walnut

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.