

No. 2
-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. **31930**

FILED OCT 18 1940

2811

540413

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH: Dunklin

(a) County Dunklin

(b) City or town Gibson
(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 whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin

(c) City or town Gibson
(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 Jessie F Todd

3. (b) If veteran ✓ name war _____

3. (c) Social Security No. ✓

4. Sex Female 5. Color or race W.

6. (a) Single, widowed, married, divorced m ✓

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

7. Birth date of deceased June 28 1899
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>6</u>	<u>20</u>	hr. min.

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

10. Usual occupation house wife

11. Industry or business _____

12. Name Floyd

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

14. Maiden name Florence E Smith

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

16. (a) Informant B. J. Todd

(b) Address Gibson, Mo

17. (a) _____ (b) Date thereof 1-17-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation North Cannon Cem

18. (a) Signature of funeral director Parishus Terrence

(b) Address Campbell Mo

19. (a) Oct. 10-1940 (b) H. Anderson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17
year 1940 hour 3:30 minute ✓ M.

21. I hereby certify that I attended the deceased from Feb 2 1939 to Jan 17 1940
that I last saw her alive on Nov-10 1939
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Hepatitis

Due to Cholecystitis

Other conditions (Include pregnancy within 3 months of death) 17 1/2

Major findings: Of operations NO

Of autopsy NO

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) _____
While at work? _____ (e) Means of injury _____

23. Signature A. L. Smith (M. D. or other) _____
Address Cape Girardeau Date signed 1/19/40

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

MOTHER FATHER

RECEIVED

District Health Officer No. 2

District File Number 1040-150

Date Filed 10/14/40

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.....

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.