

Registration District No.

309 OCT 23 1940

Primary Registration District No.

4185

Registrar's No.

28

1. PLACE OF DEATH:

- (a) County Gentry
 (b) City or town Albany
 (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) (If rural, give location)

3. (a) PRINT FULL NAME Lucinda Canaday3. (b) If veteran,
name war3. (c) Social Security
No.4. Sex Female5. Color or
race White6. (a) Single, widowed, married,
divorced Married6. (b) Name of husband or wife
Edward Canaday6. (c) Age of husband or wife if
alive 2 years
1862 (Year)7. Birth date of deceased Dec.
(Month)2 (Day)1862 (Year)

8. AGE:

Years

Months

Days

If less than one day

7792

hr. min.

9. Birthplace Gentry County
(City, town, or county)Missouri
(State or foreign country)10. Usual occupation house wife

11. Industry or business

12. Name Frederick Summa13. Birthplace South Carolina
(City, town, or county)

(State or foreign country)

14. Maiden name Highley Long15. Birthplace So. Carolina
(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature Ed. Canaday(b) Address Albany, Mo.17. (a) Burial (Burial, cremation, or removal)(b) Date thereof Sept. 5, 1940
(Month) (Day) (Year)(c) Place: burial or cremation Grandview18. (a) Signature of funeral director W. G. Martin

(b) Address

19. (a) Sept 4, 1940 (Date received local registrar)(b) W. G. Martin (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Gentry
 (c) City or town Albany
 (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 Sept. day 4
year 1940 hour 12:55AM minute _____ M.21. I hereby certify that I attended the deceased from 12:55 AM to Sept 5, 1940
that I last saw her alive on Sept 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Exacerbation of chronic disease of stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically

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. N. Barger (M. D. or other) _____
Address Albany Mo Date signed 9-3-40

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.

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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 me

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

Signed Clifford Burns

..... Licensed Embalmer No. 3329

..... P. O. Address Albany Mo

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. **31990**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **309**

Primary Registration District No. **4185-**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Henry**
(b) City or town **Henry**
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME **Lucinda Casady**

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 **77** Months **9** Days **2** If less than one day _____ hr _____ min.

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) _____ (Date received local registrar) _____ (Registrar's signature)

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.

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 **Carcinoma of**

Stomach + Liver
Due to **Primary Site Sept**
Breast.

Other conditions _____ (Include pregnancy within 3 months of death) **50**

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) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

MEDICAL CERTIFICATION

Physician

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

