

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. 3029

Registrar's No. 274

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Elizabeth
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Ollinois (b) County Oshea
 (c) City or town Kinderhook
 (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 Walter Gresham
 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 Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 3 1940
 (Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name Charles Kirkpatrick
 13. Birthplace Winchester Illinois
 (City, town, or county) (State or foreign country)
 14. Maiden name Leona Gresham
 15. Birthplace Detroit, Mich. Co. Del.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lena Gresham
 (b) Address Kinderhook, Illinois

17. (a) Burial (b) Date thereof Sept 19 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kinderhook Ill

18. (a) Signature of funeral director Barry W. Fisher
 (b) Address _____

19. (a) Sept 17 1940 (b) _____
 (Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17
 year 1940 hour 11:55 minute _____ M. _____
 21. I hereby certify that I attended the deceased from Sept 9,
 1940, to September 17, 1940;
 that I last saw her alive on September 17, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, disseminated
8 days to my knowledge had been ill
 Due to _____ 4 weeks

Due to _____
 Other conditions Acute Purulent Otitis Media 8 days
 (Include pregnancy within 3 months of death)

Major findings: None
 Of operations _____
 Of autopsy Permission not granted
 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) no

(b) Date of occurrence no

(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?
no
 (Specify type of place) (e) Means of injury _____

23. Signature Harrell B. Landrum D. or other
 Address _____ Date signed 9/17/40

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 importa

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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.....

....., 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 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. **32544**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Merion**
(b) City or town **Harmond**
(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 (Specify whether _____)

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

Wilma Breshaw

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 **S**

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.

4 14

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 _____

(Burial, cremation, or removal)

(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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **17**
year **1948** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
that last saw him _____ alive on _____ 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia, Disseminated**
Due to **Broncho pneumonia**
Due to _____

Other conditions **acute purulent otitis**
(Include any within 5 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.
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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) (If means of injury)

23. Signature **Daniel B. Jordan** (M. D. or other) _____
Address **Harmond, Mo.** Date signed **11/29/48**

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

Daniel B. Jordan

SUPPLEMENTARY

