

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32718
Registrar's No. 118

Registration District No. 025 Primary Registration District No. 3031

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Maryville, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Frances Erma Larson
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 Dale Larson 6. (c) Age of husband or wife if alive 21 years
7. Birth date of deceased April 23, 1919
(Month) (Day) (Year)

8. AGE: Years 21 Months 4 Days 11 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Elza Bodle

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

14. Maiden name Bertha Logan
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Elza Bodle
(b) Address 514 Sidmore, Mo.

17. (a) Burial (b) Date thereof 9/6/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mound City, Mo.

18. (a) Signature of funeral director W. L. ...
(b) Address Mound City, Mo.

19. (a) Sept 6, 40 (b) Manuel E. Clardy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Holt
(c) City or town Craig
(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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 7 year 1940 hour 8:00 minute _____ M.
21. I hereby certify that I attended the deceased from 9/3, 1940 to 9/4, 1940
that I last saw him alive on 9/4 and that death occurred on the date and hour stated above.
Immediate cause of death: Rupture of anterior wall in to abdomen
Due to creasing peritonitis + hemorrhage. Duration 2 1/2
Due to acute abdomen peritonitis 14 1/2 12 hrs 24 hrs
Other conditions to have occurred during labor & delivery of
Major findings: Of operations: Hydrocephalus infant
Of autopsy as above
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? 5-5-6
(Specify type of place) (e) Means of injury _____
23. Signature: D. H. ... (M. D. or other) _____
Address Quincy, Mo Date signed 9/5/40

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.

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.....

M. Crawford

Licensed Embalmer No. *1824*

P. O. Address *Mound City 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.