

1-10-37
17-39
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FILED NOV 15 1940
406 417

Registration District No. 406 417 Primary Registration District No. 5560 302 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence at 331 South Liberty St. 2
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Carl Junction
(If outside city or town limits, write "RURAL")
(d) Street No. 1 mi West of Carl Junction
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME MARY E. MONROE

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 widowed
6. (b) Name of husband or wife John Monroe 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 20 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 9 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Jim Robertson
18. Birthplace Tennessee (City, town, or county) (State or foreign country)
14. Maiden name Mary Kennedy
15. Birthplace Tennessee (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Chas. Dawne

(b) Address Carl Junction, Mo.

17. (a) Burial (b) Date thereof 10-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Carl Junction Cemetery

18. (a) Signature of funeral director Poppy Funeral Services

(b) Address Carl Junction, Mo.

19. (a) 10-24-40 (b) Ray M. Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 23
year 1940 hour 6 minutes 15 P.M.

21. I hereby certify that I attended the deceased from Oct - 17, 1940 to Oct - 23, 1940
that I last saw him alive on Oct - 23, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Previous attack

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 _____
(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
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M. D. or other (M. D. or other) no
Address Webb City, Mo Date signed 10-24-40

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

40-11-501

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

Rollins Knott

Licensed Embalmer No. *3685*

P. O. Address *Coal Junction, 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. **35-602**
Registrar's No. **152**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **417**

Primary Registration District No. **3021**

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

1. PLACE OF DEATH:
 (a) County **Franklin**
 (b) City or town **Wesley city**
(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)

3. (a) PRINT FULL NAME **Mary E Monroe**
3. (b) If veteran, name war _____ **3. (c) Social Security No.** _____

4. Sex **7** **5. Color or race** **W** **6. (a) Single, widowed, married, divorced** **wid**
6. (b) Name of husband or wife _____ **6. (c) Age of husband, or wife, if alive** _____ years

7. Birth date of deceased **1 20 1861**
(Month) (Day) (Year)

8. AGE: Years **79** Months **9** Days **3**
If less than one day, hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER { **12. Name** **John R. Knight**
13. Birthplace _____
(City, town, or county) (State or foreign country)

MOTHER { **14. Maiden name** **Mary K. Kennedy**
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Chas Downs**
(b) Address **Carl Jet, mo**

17. (a) Burial, cremation, or removal **Burial** **(b) Date thereof** **10-28-1940**
(Month) (Day) (Year)
(c) Place: burial or cremation **Carl Jet Cem**

18. (a) Signature of funeral director **Poney Funeral Home**
(b) Address _____

19. (a) DECE PER 28.40 **(b) J. L. Pritchard, M.D.**
(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.

MEDICAL CERTIFICATION
20. DATE OF DEATH Month **10** day **23**
 year **1940** 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 **Cerebral hemorrhage**
Previous attacks _____
 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?
 While at work? _____
(Specify type of place) (e) Means of injury.
23. Signature _____ (M. D. or other)
 Address _____ Date signed _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35602

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 417

Primary Registration District No. 3021

Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Webb City
(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
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary E. Monroe

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 wid
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 79 Months 9 Days 3 If less than one day min.

9. Birthplace Friendship Tennessee (City, town, or county) (State or foreign country)

10. Usual occupation.
11. Industry or business.
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year) (c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH month 10 day 23 year 1940 hour minute M.

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

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?

While at work? (Specify type of place)
23. Signature M. S. Haughester M.D. or other Address Webb City Mo. Date signed

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER