

132

RECEIVED

District Health Officer No. 10

District File Number 11-40-2125

Date Filed NOV 13 1940

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35-781**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **533**

Primary Registration District No. **5713**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Macon
 (b) City or town Hudson Twp
(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 Miss Helen Beatty
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex m **5. Color or race** w
6. (a) Single, widowed, married, divorced _____
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 60- Months 5- Days 24
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 _____
(City, town, or county) (State or foreign country)
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)

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 Oct day 3
 year _____ hour _____ minute _____ M.

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

Immediate cause of death Arteriosclerosis
 Due to _____
 Due to _____

Other conditions Myo Carditis
(Include pregnancy within 6 months of death)
Interstitial Nephritis
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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature Anna P. March (M. D. or other) _____
 Address Macon Mo Date signed _____

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

ROWENA MOORE

SUPPLEMENTAL

Duration

PHYSICIAN

 Underline the cause to which death should be charged statistically.

