

STANDARD CERTIFICATE OF DEATH

35839

State File No. \_\_\_\_\_

Registration District No. 5-61

Primary Registration District No. 5753

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Dean Rural - Saline  
(If outside city & 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 \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County Miller

(c) City or town Rural near Dean Mo  
(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 CLEMENTINE DOLL

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 \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 7 1848  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21  
year 1940 hour 5 minute 50 P.M.

21. I hereby certify that I attended the deceased from 9/15, 1939, to 10/21, 1940, that I last saw her or him alive on 9/30, 1940 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

92 9 14 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name John McLeod

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

14. Maiden name Eliza Cole

15. Birthplace PA  
(City, town, or county) (State or foreign country)

Immediate cause of death Senility

Due to arterio-sclerosis

Other conditions (Include pregnancy within 3 months of death) an

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant Lillian D. Martin

(b) Address Dean Mo

17. (a) Removal (b) Date thereof Oct 23 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Novelty Mo

18. (a) Signature of funeral director Keith M. Kaye

(b) Address Eldon Mo

19. (c) Oct 24-1940 (b) Belle Haynes  
(Date received local registrar) (Registrar's signature)

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? 495  
While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature G. D. Waller (M. D. or other) MD

Address Eldon Mo Date signed 11/5/40

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

6

RECEIVED

Miller County Health Dep't.

County File Number 40-101

Date Filed 11/12/40

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 Keith M. Kaye  
Licensed Embalmer No. 3998  
P. O. Address Eldon 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..