

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36677

Registration District No. 899 Primary Registration District No. 6205 State File No. _____ Registrar's No. 6

1. PLACE OF DEATH:
 (a) County Webster
 (b) City or town Marshfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
County Farm
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution One Year 3
 (Specify whether years, months or days) One Year

3. (a) PRINT FULL NAME KATIE BLAUE
 3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Unknown
 6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Unknown
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 X X hr. min.

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

10. Usual occupation Unknown 9

11. Industry or business X
 MOTHER FATHER { 12. Name Blau 9
 13. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dow Cliff
 (b) Address Marshfield, Mo.

17. (a) Burial (b) Date thereof June 1 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
Marshfield
 (c) Place: burial or cremation

18. (a) Signature of funeral director Rex Rainey
 (b) Address Marshfield, Mo.
 19. (a) May 10 (b) E. M. Bailey
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Webster
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Marshfield, R.F.D.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION ...
 20. DATE OF DEATH, Month May day 31
 year 1940 hour 5 p.m. minute 47 P.M.
 21. I hereby certify that I attended the deceased from Sept. 20
1940 to May 31 1940
 that I last saw her alive on May 10 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Cancer Rectum
 Due to _____
 Due to _____ 46
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____
 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?
 While at work (Specify type of place) (e) Means of injury _____
 23. Signature E. M. Bailey (M.D. or other) _____
 Address Marshfield Date signed May 31 1940

RECEIVED

District Health Officer No. 6,

District File Number 1040-2779

Date Filed OCT 25 1940

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.