

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

17-39
X21492

Registration No. 156

Primary Registration District No. 5219

Registrar's No. 56

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Rural Grandriver Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
No 2 Hwy, 1/4 mi East of Harrisonville
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 44 years
years, months or days) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Rural Grandriver
(If outside city or town limits, write "RURAL")
(d) Street No 1/4 mi East of Harrisonville
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

8. (a) PRINT FULL NAME Martha Ann Calhoun

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced W.

6. (b) Name of husband or wife Deceased. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 25 1857
(Month) (Day) (Year)

8. AGE: Years 83 Months 1 Days 19 If less than one day hr. _____ min. _____

9. Birthplace Grasson Co Va.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired housewife

11. Industry or business 9

12. Name Joseph Bennett 9

13. Birthplace unknown
(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 Mrs Geo Garton
(b) Address Harrisonville Mo

17. (a) Burial (b) Date thereof 11-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellton Cem.

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

19. (a) 11/16/40 (b) Beekusky M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 15
year 40 hour between 1-5 minute _____ M.

21. I hereby certify that I attended the deceased from 11-13-40
11-14 1940 to 11-14 1940
that I last saw her alive on Nov 14 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Seizure, auricular fibrillation

Due to Fracture Right Hip

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy no

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?

845 (Specify type of place)
While at work? _____ (e) Means of injury _____

28. Signature Beekusky (M. D. or other) M.D.

Address Harrisonville Date signed 11/16/40

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

144 B
99

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 *Floyd Robinson*

Licensed Embalmer No. 5920

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38426
Registrar's No. 57

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 15-6

Primary Registration District No. 2219

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

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Grandriver
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Martha Ann Calhoun

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 83 Months 1 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace _____ (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) _____ (b) Date thereof _____ (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 _____ day _____ year _____ hour _____ minute _____ M.

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

Immediate cause of death
Seriously Auricular
Fibrillation of
Fracture of Hip
rest of femur
fall

Other conditions _____ (Include pregnancy within 3 months of death) 186 W

Major findings: _____ Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accidental

(b) Date of occurrence Oct 21, 1940

(c) Where did injury occur? Home, Harrisonville Mo (City or town) Cass 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 Fall

23. Signature Edw. M. D. (M. D. or other) _____

Address Harrisonville Mo Date signed 2/14/41

SUPPLEMENTARY

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

11/16/40

