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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38525

Registration District No. 212

Primary Registration District No. 3014

Registrar's No. 312

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

1. PLACE OF DEATH:  
(a) County Cole  
(b) City or town Jefferson City, Mo.  
(c) Name of hospital or institution:  
St. Marys Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether  
In this community years, months or days) 1

3. (a) PRINT FULL NAME Angeline Theresa Bax  
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 Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased February 14, 1922  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
18 9 15 hr. min.

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

10. Usual occupation House Work

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Edw B. Bax  
13. Birthplace St. Elizabeth, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Scheler  
15. Birthplace Westphalia, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Edw B. Bax  
(b) Address Meta, Mo.

17. (a) Burial (b) Date thereof 12-2-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. George Cemetary Linn

18. (a) Signature of funeral director Morton Funeral Home  
(b) Address Box 144, Linn, Mo.

19. (a) 11-30-40 (b) D. W. Besford, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Osage  
(c) City or town Meta, 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.? 0 years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov 29 day \_\_\_\_\_  
year 1940 hour 7:30 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from Nov 29  
\_\_\_\_\_ 1940 to Nov 29 1940  
that I last saw h\_\_\_\_\_ alive on Nov 29 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to cardiac 18 hrs  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy ruptured liver & kidney  
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) accident  
(b) Date of occurrence Nov 29-40  
(c) Where did injury occur? Cole to car  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Highway  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury car to  
23. Signature Edw Wanner (M. D. or other) M.D.  
Address \_\_\_\_\_ Date signed 11-30-40

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**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..... *Vernon M. Mortimer*

Licensed Embalmer No. .... *4125*

P. O. Address..... *Linn*

**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, fact should be so stated above.**

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STANDARD CERTIFICATE OF DEATH

State File No. 38525

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH

(a) County Cole

(b) City or town Jefferson  
(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 Angeline Theresa Bay

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 S

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 18 Months 9 Days 15  
If less than one day, in \_\_\_\_\_ 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 \_\_\_\_\_  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 11 day 29  
year \_\_\_\_\_ 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 Internal hemorrhage

Due to accident 11/29/40

Due to Driver of car ran off road & crashed

Other conditions no other vehicle involved  
(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) accident

(b) Date of occurrence 11-29-1940

(c) Where did injury occur? Cole Co Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place

While at work? \_\_\_\_\_  
(Specify place of place) (e) Means of injury auto

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

