

JAN 25 1941

Registration District No. **248** Primary Registration District No. **5245** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County **Davies, Indiana**  
(b) City or town **Rural Spencer, Ind.**  
(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 \_\_\_\_\_  
In this community **6 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Dollie Stuart**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **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 **Aug 9 1897**  
(Month) (Day) (Year)

8. AGE: Years **43** Months **2** Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Dekalb Co Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

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

12. Name **Joseph Daves**

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

14. Maiden name **Martha York**

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

16. (a) Informant **Raymond Riddler**

(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 **Lucile M Wilson**

(b) Address **King City Mo**

19. (a) **10-20** (b) **Wm E Riddler**  
(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 **Oct** day **9th**  
year **1940** hour **11** minute **30 A. M.**

21. I hereby certify that I attended the deceased from **Oct 6**  
**1940**, to **Oct 9th** **1940**;  
that I last saw h. **or** alive on **Oct 8** **1940**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**

Due to **Complicated with hyperemia**

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(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) \_\_\_\_\_

(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? \_\_\_\_\_

**225** While at work? \_\_\_\_\_ (Specify type of place)  
(a) Means of injury \_\_\_\_\_

23. Signature **A. L. Harvey M.D.**

Address **Ridder Mo** Date signed **10-9-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

I X21492

**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

*Lucile M. Wilson*

Licensed Embalmer No.

*2830*

P. O. Address

*King City 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 42346

Registration District No. 246

Primary Registration District No. 5345

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

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

1. PLACE OF DEATH:

(a) County Davess  
(b) City or town \_\_\_\_\_  
(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 Rollie Stuart

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 wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)  
8. AGE: Years 43 Months 2 Days \_\_\_\_\_ 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Mrs J L Resch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town about known  
(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 9  
year 1940 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 \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(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) \_\_\_\_\_  
(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 A. L. Dorsey (M. D. or other) \_\_\_\_\_  
Address Kiddes Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

