

16-2  
17-39  
K2315

FEB 24 1941 260  
Registration District No.

Primary Registration District No. 2363A

Registrar's No.

1. PLACE OF DEATH:  
 (a) County De Kalb  
 (b) City or town Cameron Mo.  
 (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 MARGARET ANN EADS  
 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 Sept 17, 1940  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 3 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name Harold Eads  
 13. Birthplace Lock Springs Mo (City, town, or county) (State or foreign country)  
 14. Maiden name Mrs. Marine Clark  
 15. Birthplace Brown Co Kansas (City, town, or county) (State or foreign country)

16. (a) Informant Harold B. Eads  
 (b) Address Mitchell, Mo.

17. (a) Burial (b) Date thereof 1-16-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Freemasons Cemetery

18. (a) Signature of funeral director Chas. M. ...  
 (b) Address \_\_\_\_\_

19. (a) 1-16-41 (b) Chas. M. ...  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County De Kalb 32  
 (c) City or town Cameron, Mo. 1  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 812 North Main (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15<sup>th</sup>  
 year 1941 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 9  
 \_\_\_\_\_, 1941, to Jan 9, 1941  
 that I last saw him alive on \_\_\_\_\_, 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia, Bronchitis ✓

Due to malnutrition

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?  
 \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. P. Kinies (M. D. or other) \_\_\_\_\_  
 Address Cameron Mo Date signed Jan 15 41

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

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

MOTHER FATHER

107

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was <sup>not</sup> ~~embalmed~~ by me, or by \_\_\_\_\_

Body was not Embalmed, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed C. Moore

Licensed Embalmer No. 1180

P. O. Address Cameron, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2411

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 260

Primary Registration District No. 0363A

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

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

1. PLACE OF DEATH:

(a) County DeKalb

(b) City or town Cameron  
(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 Margaret Ann Eads

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 8

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 Months Days If less than one day

Years	Months	Days	If less than one day
	<u>3</u>	<u>28</u>	h. _____ 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 Jan day 12 year \_\_\_\_\_ 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: Pneumonia Bronchial

Due to malnutrition

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 J. D. Kines (M. D. or other) \_\_\_\_\_

Address Cameron Mo Date signed \_\_\_\_\_

MEDICAL CERTIFICATION

Duration 7 days

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

