

5-17-39
X21492

FEB 14 1941

Registration District No. 287

Primary Registration District No. 5405 4171

Registrar's No. 49

3500
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Harrisonville, mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Dr Van H. Bond, Office
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Dunklin
(c) City or town Senath Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 2 miles east 2 m. south
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Evelyn Marie Altman

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

7. Birth date of deceased march 2 - 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Senath MO
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER { 12. Name Bryant J. Altman
13. Birthplace Burnett County Texas
(City, town, or county) (State or foreign country)
14. Maiden name Nettie R. Owens
15. Birthplace Clay County Ark
(City, town, or county) (State or foreign country)

16. (a) Informant Bryant J. Altman

(b) Address Senath, Mo. Rte. 1

17. (a) Burial (b) Date thereof. 1-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blacks

18. (a) Signature of funeral director E. Merson, Burns

(b) Address Harrisonville, mo

19. (a) 1-3-41 (b) E. J. Cox
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2
year 1941 hour 9:30 minute 0 M.

21. I hereby certify that I attended the deceased from Dec 27, 1940, to Jan 3, 1941, that I last saw her alive on Jan 2, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia
Due to Influenza
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Van H. Bond (M. D. or other) _____
Address Harrisonville mo Date signed _____

STATE OF ILLINOIS

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.

No. 2B
2-21-40
X22659

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

ROWENA MOORE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 2450

Registration District No. 287

Primary Registration District No. 4171

Registrar's No. _____

1. PLACE OF DEATH:

(a) County DeKalb

(b) City or town Farmersville
(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)

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.

3. (a) PRINT FULL NAME Evelyn Marie Altman

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 Inf

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

7. Birth date of deceased Mar - 2 - 1940
(Month) (Day) (Year)

20. DATE OF DEATH: Month Jan day 2
year 1941 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 _____

8. AGE: Years _____ Months 10 Days _____ If less than one day _____ hr _____ min.

Due to _____

Due to _____

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

Major findings:
Of operations _____

Of autopsy _____

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

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) 1-25-41 (b) E. H. Cope
(Date received local registrar) (Registrar's signature)

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 Wm H. Bond (M. D. or other) _____
Address Farmersville _____

SUPPLEMENTAL

