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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3211

Registration District No. 491

Primary Registration District No. 3634

Registrar's No. 3

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000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Rural
(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 Cora Elizabeth Means

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Asa Means

6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased March 11, 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

70 : 10 : 11 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Franklin Miller

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

14. Maiden name Elizabeth Willis

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

16. (a) Informant R. F. Means

(b) Address R. F. D. #2, Pierce City, Mo

17. (a) Burial (b) Date thereof Jan. 24, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation I.O.O.F. Cemetery

18. (a) Signature of funeral director Leahuray

(b) Address _____

19. (a) Jan. 23 (b) C. B. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 22nd.
year 1941 hour 2:30 A.M. minute _____ M.

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

Immediate cause of death Cerebral Hemorrhage 20 days

Due to Arterial sclerosis

Due to _____

Other conditions Influenza 3 days
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration

PHYSICIAN

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) _____

(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? 422

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

23. Signature Jud. D. Harrowe, M.D. (M. D. or other) 0

Address Madett, Missouri Date signed 1-22-41

RECEIVED
DISTRICT HEALTH OFFICER
FEB 11 1947
E. V. BEHRENS & ALBINO

RECEIVED
District Health Officer No. 61
District File Number 241-264
Date Filed FEB 11 1947

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.....

J. D. Buchanan

Registered Apprentice No.

working under my personal supervision.

Signed *J. D. Buchanan*

Licensed Embalmer No. 3179

P. O. Address *Worth Ave*

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

Registration District No. 471

Primary Registration District No. 5634

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Prarie T. P.
(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 Corra Elizabeth Means
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 m
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 70 Months 10 Days 11 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 _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) E. B. Wright (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 22
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 _____

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 Fred Hargrove (M. D. or other) _____

Address Monett Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

MOTHER FATHER

