

5-17-39
K21492

FEB 25 1941

Registration District No. **954** Primary Registration District No. **6080** Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
 (b) City or town Russell - Current - Ind. In
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 1200 W. 1st St. Russell
(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 Shannon
 (c) City or town Russell
(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 Cornelius J. Made

3. (b) If veteran, name war X 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rhoda Made 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased June 17 - 1885
(Month) (Day) (Year)

8. AGE: Years 55 Months 7 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

MOTHER FATHER

11. Industry or business _____
 12. Name James A. Made

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

14. Maiden name Rhoda G. Conner

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

16. (a) Informant John Martin

(b) Address Russell Mo

17. (a) Russell (b) Date thereof Jan 30 - 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Waters Cemetery

18. (a) Signature of funeral director None

(b) Address _____

19. (a) 1-29-41 (b) Frank Heyde MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1
 year 1941 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 A. Cancer of prostate #

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? 744

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

23. Signature Frank Heyde (M. D. or other) 0

Address Russell Mo Date signed 1-29-41

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

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

200B

RECEIVED
District Health Officer No. 5,
District File Number 241277
Date Filed _____

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 45-48

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 954

Primary Registration District No. 6080

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Moore, 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 _____ (Specify whether)
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 Cornelius J. Meade

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 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 Months Days If less than one day
55 7 12 _____ 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that last saw him alive on _____ 19 _____
that that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Prostate
Due to _____
Due to 518

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 Frank Hyde (M. D. or other)

Address Quinnell Mo Date signed 1-30-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

