

REGISTRATION DISTRICT NO. 139

Primary Registration District No. 4079-5199

Registrar's No. 4

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

1. PLACE OF DEATH:

(a) County Carroll
 (b) City or town Tina, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Home at Tina, Missouri.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 years,
 In this community 3 years,
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME MINNIE ALICE LITTLE

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 Widowed

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

7. Birth date of deceased Aug. 15th, 1876
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 5 17 hr. _____ min.

9. Birthplace Kentucky, Trimball/County.
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife,

11. Industry or business _____

MOTHER FATHER { 12. Name James H. Suddith,
 13. Birthplace Kentucky /
 (City, town, or county) (State or foreign country)
 14. Maiden name Ivda Markwell,
 15. Birthplace Kentucky, /
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Bertha Key,
 (b) Address Carrollton, Missouri.

17. (a) burial, (b) Date thereof 2/4/1941.
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Coloma

18. (a) Signature of funeral director Clifford W Austin

(b) Address Tina Missouri

19. (a) 2-4-41 (b) Mrs R.A. Henderson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI. (b) County Carroll 17
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. Tina (Rural) (If rural, give location)
 (e) If foreign born, how long in U. S. A.? USA. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2nd, day February
 year 1941. hour 9:30 minute A.M.

21. I hereby certify that I attended the deceased from June 31, 1941
 _____, 19____, to Feb 2, 19____
 that I last saw her alive on Feb 2, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Intestinal Obstruction / Stage

Due to _____
 Due to _____

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

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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?

13'
 While at work? _____ (Specify type of place)
 (e) Means of injury g

23. Signature R. L. Smith (M. D. or other) DO
 Address Tina, Mo Date signed 2-3-41

12218

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 3-6-41

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 _____

Clifford W. Austin,

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Clifford W. Austin

Licensed Embalmer No. 3233.

P. O. Address Tina, Missouri.

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.

STATEMENT BY REGISTERED EMBALMER

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

65-96
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 139
 (b) Township Stokes mound Primary Registration District No. 5194
 (c) City..... (d) Street No..... Registered No.....
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Missie Alice Little

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 5 17

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as bank mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19.....

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 2 1941

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Intestinal Obstruction Date of onset

Mesenteric Thrombosis 10 days

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify

(Signed) Everett R. Smith, M. D.

(Address) Tanna mo

SUPPLEMENT

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-6590