

No. 2
-13-40
17-39
X23159

DEPARTMENT OF HEALTH
BUREAU OF THE CENSUS
FEB 17 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7377

State File No. 2

Registration District No. 450

Primary Registration District No. 5615

Registrar's No. 2

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

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Rural, Anglaise Sup
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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 Minnie Bell Oliver

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, widowed

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

7. Birth date of deceased Oct 31 1869
(Month) (Day) (Year)

8. AGE, Years	Months	Days	If less than one day
<u>71</u>	<u>2</u>	<u>11</u>	hr. _____ min.

9. Birthplace Greene Co Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name James N. Uland

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

14. Maiden name Magdelene Morse

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

16. (a) Informant A. W. Oliver

(b) Address Sleepers, Mo.

17. (a) burial (b) Date thereof Jan 13 1941
(Burial, cremation, or removal) (Month), (Day) (Year)

(c) Place: burial or cremation Cox Crossing

18. (a) Signature of funeral director W. E. Holman

(b) Address Lebanon, Mo.

19. (a) Feb 20 - 1941 (b) D. A. Atkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede

(c) City or town Rural Anglaise Sup
(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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 12
year 1941 hour 1 minute 15 A.M.

21. I hereby certify that I attended the deceased from Jan 11, 1941, to Jan 12, 1941
that I last saw her alive on Nov 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular heart disease

Due to _____

Due to _____

Other conditions Chronic Arthritis
(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? 405

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature C. E. Carlton (M. D. or other) 1

Address Stoutland Mo Date signed Jan 15, 1941

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 1,

District File Number 3-41-331

Date Filed 3-13-41

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.....

myself

..... Registered Apprentice No.....

working under my personal supervision.

Signed

W. E. Holman

Licensed Embalmer No. 4107

P. O. Address Lebanon, Mo.

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, fact should be so stated above.