

No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8458**

Registration District No. **878**

Primary Registration District No. **666**

Registrar's No. **4**

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

1. PLACE OF DEATH:
(a) County **Vernon**
(b) City or town **Rural Dole No. 7**
(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 **40 yrs** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Vernon 108**
(c) City or town **Rural Dole Township**
(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.?

3. (a) PRINT FULL NAME **AMELIA-KATE-CROSS**
3. (b) If veteran, name war. 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **7**
year **1941** hour **10** minute **P** M.

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

21. I hereby certify that I attended the deceased from
March 8, 1940, to **Jan 30**, 1941;
that I last saw her alive on **Jan 30**, 1941,
and that death occurred on the date and hour stated above.

7. Birth date of deceased **Mar. 6 1859**
(Month) (Day) (Year)

Immediate cause of death **Influenza** Duration **2 wks.**
Terminal Bronchopneumonia **3 days**
Due to **Hypertensive Cardio-vascular** **7 years**
renal disease

8. AGE: Years Months Days If less than one day
81 11 1 hr. min.

Due to
Other conditions (Include pregnancy within 3 months of death)

9. Birthplace **unknown 1 Kentucky**
(City, town, or county) (State or foreign country)
10. Usual occupation **Home wife**
11. Industry or business
12. Name **William Fields**
13. Birthplace **unknown 100 Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Kathryn Southern**
15. Birthplace **unknown 9 Kentucky**
(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 **Ray Cross**
(b) Address **Sheldon mo R# 2**
17. (a) **Rural** (b) Date thereof **Feb 9 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **olive branch**
18. (a) Signature of funeral director **G. B. Berry & Son**
(b) Address **Sheldon mo**
19. (a) **Feb 8 1941** (b) **Coull T. Berry**
(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?
7 A 2
While at work? (Specify type of place)
Means of injury
23. Signature **Thomas G. Duckett** (M. D. or other) **MD**
Address **Sheldon mo** Date signed **2/8/41**

RECEIVED

District Health Officer No. 7
District File Number 3-41-461
Date Filed 3-7-41

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.....

....., 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, fact should be so stated above.