

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—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.

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

8524
Do not use this space.

1. PLACE OF DEATH

(a) County WEBSTER Registration District No. 496
 (b) Township OSARK Primary Registration District No. 6198/112 Registered No. 8
 (c) City _____ (d) Street No. _____ St.
 (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

MARTHA JANE PETTY
 (a) Residence, No. Marshfield mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF MANUEL PETTY
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) FEB. 2 - 1872
 7. AGE YEARS 68 MONTHS 9 DAYS 17 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Herrings
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN 19 1941
 22. I HEREBY CERTIFY That I attended deceased from Oct 15 1940 to Jan 17 1941
 I last saw him alive on Jan 17 1941. Death is said to have occurred on the date stated above, at 3 a. m.
 The principal cause of death and related causes of importance were as follows:
Congestive Heart Failure
Cerebral Hemorrhage
Arterio Sclerosis
Chronic Nephritis
 Date of onset _____

Other contributory causes of importance: _____

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

FATHER 13. NAME CAGE NEASBA
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No RECORD?

MOTHER 15. MAIDEN NAME " "
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "

17. INFORMANT (NAME) Paul Lee Rice
 (ADDRESS) Marshfield mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Marshfield Mo DATE JAN 20 1941

19. FUNERAL DIRECTOR (NAME) McMAHAN FUNERAL SERVICE
 (ADDRESS) MARSHFIELD, MO

20. FILED Feb 1 1941 Clayton Hedges
 Local Registrar

Name of operation NONE 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 6, 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) W. H. Spencer M.D.
 (Address) Marshfield - mo.

524

RECEIVED

District Health Officer No. 6.

District File Number 341465

Date Filed 12-1-1941

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 A. S. M. M. M. M. M.

Licensed Embalmer No. 1779

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

3. No. 2
-1-4-41
5-17-39
PI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 85-24

Registration District No. 896

Primary Registration District No. 6198

Registrar's No.

1. PLACE OF DEATH:

(a) County Webster

(b) City or town Osark
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Martha Jane Getty

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19
year 1941 hour _____ minute _____ M.

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

4. Sex F

5. Color or race W

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

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

Immediate cause of death Congestive heart failure Duration _____

8. AGE: Years 68 Months 9 Days 17 If less than one day _____ hr. _____

Due to Cerebral Hemorrhage
Arterio Sclerosis
Chronic Nephritis

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

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

10. Usual occupation _____

11. Industry or business _____

Major findings: Of operations _____

12. Name _____

Of autopsy _____

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

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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? _____

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

23. Signature W. H. Spencer (M. D. or other) 200

Address Marshfield Date signed 5/24/41

(Licensed Embalmer's Statement on Reverse Side)

SUPPLEMENTAL

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

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.