

FILED APR 15 1941
Registration District No. **549**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Hamersburg, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **St. Joseph's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **19 days**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Jackson**
(c) City or town **Eureka** **14**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **2** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **4**
year **1941** hour **8** minute **35 A.** 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 **Acute Cardiac Dilatation**

Due to **Organizing Pneumonia**

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 **D**
23. Signature **H.C. H. King** (M. D. or other)
Address **St. Joseph's Hospital** Date signed **5/17/41**

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

3. (a) PRINT FULL NAME **MRS. MARTHA NEVILLE**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married **1** divorced **Married**

6. (b) Name of husband **CHAS. F. NEVILLE** 6. (c) Age of husband or wife if alive **71** years

7. Birth date of deceased **July 10 1871**
(Month) (Day) (Year)

8. AGE: Years **69** Months **7** Days **24** If less than one day _____ hr. _____ min.

9. Birthplace **1 Wisconsin**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

12. Name **John Graham**

13. Birthplace **4 England**
(City, town, or county) (State or foreign country)

14. Maiden name **Angelina Schellinger**

15. Birthplace **1 Wisconsin**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles F. Neville**

(b) Address **Eureka, Kansas**

17. (a) **Burial** (b) Date thereof **3-6-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Eureka, Kansas**

18. (a) Signature of funeral director **Freeman Mortenson**

(b) Address **104 West 42nd Street**

19. (a) **MM 5-41** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

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

of 608

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 *Clement W. Clark*

Licensed Embalmer No. *3473*

P. O. Address *7c 7160*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 925

1. PLACE OF DEATH:

(a) County
(b) City or town
(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)

3. (a) PRINT FULL NAME Mrs Martha Kerville

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

4. Sex 5. Color or race 6. (a) Single, widowed, married, divorced
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 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5/10/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month March day 4 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.

Immediate cause of death ac dilatation of heart Duration

Due to Organizing Pneumonia

Due to Tuberculosis 10/8

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

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?

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

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

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

2

9516