

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10006**

Registration District No. **1041**

Primary Registration District No. **5107**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Ballinger**
(b) City or town **Grisham**
(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
In this community **Liptona** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **G. L. Adys Pauline CURETON**

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 **2**
6. (b) Name of husband or wife 6. (c) Age of husband or wife If alive years
7. Birth date of deceased **Sept. 20, 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 8 hr. min.

9. Birthplace **Ballinger Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name **Robert Cureton**
13. Birthplace **Ballinger Co. Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Ferna Stragg**
15. Birthplace **Waynes Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Robert Cureton**
(b) Address **Grisham Mo.**
17. (a) **Burial** (b) Date thereof **Jan. 29, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Union City, Bessemer**

18. (a) Signature of funeral director
(b) Address

19. (a) **Jan 27 1941** (b) **Bertha M. Wilson**
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Ballinger**
(c) City or town **Grisham**
(If outside city or town limits, write "RURAL")
(d) Street No. **5** (If rural, give location)
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **28**
year **1941** hour **12:00** minute **Noon** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw her alive on **1/28/41**, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death **Pneumonia** Duration **1**

Due to _____
Due to _____

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?

While at work? (Specify type of place) (a) Means of injury
28. Signature **John M. Wilson** (M. D. or other)
Address **Grisham Mo.** Date signed **2/3/41**

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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, above space should be left blank.

Registration District No. 68

Primary Registration District No. 5107

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Bollinger
(b) City or town Union T.P.
(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

Gladys Pauline Cureton

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race W

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

4

8

hr.

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) _____ (b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) _____ (b) _____

(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia

Due to whooping cough

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration

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? _____

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

23. Signature John F. Myers (M.D. or other) _____
Address _____ Date signed 7/8/41

S-10006 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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.