

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.

FILED APR 21 1941

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

10897
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 402
 (b) Township Sumner Primary Registration District No. 4237
 (c) City Oak Grove (d) Street No. 1
 (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.

Registered No. 25

2. PRINT FULL NAME Elizabeth F. Ailor

(a) Residence, No. 1 St. 0
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F. M.</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>William F.</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 29</u>		
7. AGE	YEARS <u>86-</u>	MONTHS <u>1</u>
	DAYS <u>19</u>	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. <u>Retired</u>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Oak Grove Mo.</u>	
	13. NAME <u>Hiram K. Helm</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn</u>	
	15. MAIDEN NAME <u>Sarah Twens</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn</u>	
17. INFORMANT (ADDRESS) <u>W. R. Ailor</u> <u>Oak Grove Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL <u>Oak Burial</u> <u>Oak Grove Mo</u> DATE <u>3-21-1941</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>R. Bluebb</u> <u>Oak Grove Mo</u>		
20. FILED <u>3-22-41</u> , 19. Special Agent, Bureau of Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 19 1941

22. I HEREBY CERTIFY That I attended deceased from Feb 1, 1941, to Mar. 19, 1941
 I last saw her alive on Mar 1, 1941 Death is said to have occurred on the date stated above, at 9:30 a. m.
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage
 Date of onset Mar 1

Other contributory causes of importance:

Name of operation none Date of none
 What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 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 none
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) O. L. Taylor M. D.
 (Address) Oak Grove Mo

M. G. Ash Jackson County Health Dept
 Licensed Embalmer's Statement on Reverse Side

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 R Bluth

Licensed Embalmer No. 2353

P. O. Address Oak Grove M

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10897

Registration District No. 402

Primary Registration District No. 4237

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Oak Grove
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oak Grove (b) County Jackson

(c) City or town Oak Grove
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

3. (a) PRINT FULL NAME Elizabeth F Ailor

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 19
year 194 hour _____ minute _____ M.

4. Sex F 5. Color or race W

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

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

7. Birth date of deceased Jan 29
(Month) (Day) (Year)

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.

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

86 | 1 | 19 | _____ hr. _____ min.

Immediate cause of death _____

Due to _____

Due to _____

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

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

Major findings:
Of operations _____

Of autopsy _____

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant _____

(b) Address _____

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? _____

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 _____

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

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

23. Signature E. Lupton (M. D. or other) _____
Address Oak Grove Date signed _____

SUPPLEMENTARY

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

1941
5-10897

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.