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APR 15 1941

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

11124

State File No. \_\_\_\_\_

Registration District No. 446

Primary Registration District No. 5606

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Knox

(b) City or town Novelty (Rural) Salt River  
(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 Eight years / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 52

(a) State Missouri (b) County Knox

(c) City or town Novelty (Rural)  
(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.? D years.

3. (a) PRINT FULL NAME CARA Belle Mackey

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

4. Sex F / 5. Color or race W

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

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

7. Birth date of deceased 13 / 31 / 1883  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16<sup>th</sup>  
year 1941 hour \_\_\_\_\_ minute 5 P M.

21. I hereby certify that I attended the deceased from March 12  
1941, to March 12 1941;  
that I last saw her alive on March 12 1941;  
and that death occurred on the date and hour stated above.

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

57 2 15 10 hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ Kentucky /  
(City, town, or county) (State or foreign country)

Immediate cause of death Apoplexy

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation House Keeper

11. Industry or business \_\_\_\_\_

12. Name Charles Mackey

13. Birthplace \_\_\_\_\_ Kentucky /  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Jane Tuggle

15. Birthplace \_\_\_\_\_ Kentucky /  
(City, town, or county) (State or foreign country)

16. (a) Informant Chas Mackey  
(b) Address Novelty Mo

17. (a) Burial (b) Date thereof 3-18-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La Plata Mo

18. (a) Signature of funeral director Keith Hudson  
(b) Address Edina Mo

19. (a) Mar 18 1941 (b) Mrs C M Smith  
(Date received local registrar) (Registrar's signature)

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?  
395 (Specify type of place) (e) Means of injury 41

23. Signature E O Holmes (M. D. or D. O.)  
Address Novelty Mo Date signed 3-16-41

Duration \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 4-41-668

Date Filed APR 10 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 Keith Hudson

Licensed Embalmer No. 2413

P. O. Address Edina, Minn.

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.