

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14974

Registration District No. 460

Primary Registration District No. 4274

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Higginsville Mo.
 (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)

3. (a) PRINT FULL NAME Mrs. James Arthur (Col)

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

4. Sex 3 female 5. Color or race col. 6. (a) Single, widowed, married, divorced married

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

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

8. AGE: Years Months Days If less than one day
born 1958 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm. Johnson

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

14. Maiden name Leah Johnson
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Br. C. T. Jessell

(b) Address Higginsville Mo. 1941

17. (a) Burial (b) Date thereof April 13
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville Mo.

18. (a) Signature of funeral director _____

(b) Address Higginsville Mo. 413

19. (a) April 30-41 (b) Tiffany Webb
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 3-4
 (c) City or town Higginsville 2
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
 year 1941 hour 11:45 minute _____ A. M.

21. I hereby certify that I attended the deceased from Mar 10
1941 to Apr 10 1941;
 that I last saw him alive on Apr 8 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cancer of left ovary
2 abdominal metastases 2 wks
and intestinal obstruction 2 wks.

Due to 3

Other conditions Fecal Fistula 2 wks.
 (Include pregnancy within 3 months of death)

Major findings: Cancer of left ovary 4 wks
 Of operations _____

Of autopsy _____ 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)
 (e) Means of injury _____

23. Signature P. J. Jessell (M. D. _____)
 Address Higginsville Mo Date signed 4/19/41

RECEIVED
District Health Officer No. 8
District File Number
5-6-41 Filed

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. 3637

P. O. Address Higginville, Mo.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14974

Registration District No. 460

Primary Registration District No. 4274

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Lafayette
(b) City or town Hopkinsville
(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. MARY I. Arthur (Cal)

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex F

5. Color Black

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

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

58

9. Birthplace Texas

(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) _____

(Data received local registrar)

(b) _____

(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 _____

20. DATE OF DEATH: Month Apr day 10
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 _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

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 sta-
tistically.

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 C. T. Jessell (M. D. or other)

Address Hopkinsville Mo Date signed _____

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

