

FILED MAY 15 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **15414**Registration District No. **1099**Primary Registration District No. **5868** ✓

Registrar's No.

1. PLACE OF DEATH: *Peru, Mo*

- (a) County *Peru*  
 (b) City or town *Peru*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: *State Hosp*  
 (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 *Rosie Connor*

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex *Female* Color or race *Blk*  
 6. (a) Single, widowed, married, divorced *9*  
 6. (b) Name of husband or wife *Charles Connor* 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased *1-15-1871*  
 (Month) (Day) (Year)

8. AGE: Years *64* Months *3* Days *11* If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace *Hamer Mo* (City, town, or county) (State or foreign country)10. Usual occupation *Hand Work*

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

- MOTHER FATHER  
 12. Name *Steve Owen*  
 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 14. Maiden name *R.H.*  
 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant *Steve Connor*(b) Address *Peru Mo*

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation *Peru Mo*18. (a) Signature of funeral director *Carroll*

(b) Address \_\_\_\_\_

19. (a) *5-5-41* (b) *J. J. Creasy*  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State *Mo* (b) County *Peru*  
 (c) City or town *Peru*  
 (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.? *0* years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *26* day *Apr*  
year *1941* hour \_\_\_\_\_ minute *29* M.

21. I hereby certify that I attended the deceased from *2-1-40* to *4-23-41* 19*41*  
 that I last saw *et* alive on *4-23-41* 19*41*  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death *Uremia*

Due to *Hypertensive heart disease with renal failure* *several* years  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

- Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration *2 wks.*

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? \_\_\_\_\_  
 500 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature *R. A. Bynum* (M. D. or other) *Mo*  
Address *Peru, Mo* Date signed *5-3-41*

(Licensed Embalmer's Statement on Reverse Side)

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

5-41-29

937

STATE BOARD OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS  
PHOTOGRAPHIC UNIT  
1937

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 1099

Primary Registration District No. 5868

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Deming  
(b) City or town Little River, 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 \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Docia Tornar

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

4. Sex 7 5. Color or race Black 6. (g) Single, widowed, married, divorced \_\_\_\_\_

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

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

8. AGE: Years Months Days If less than one day  
64 2 11 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 (City, town, or county) (State or foreign country)  
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 Apr day 26  
year \_\_\_\_\_ 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 uremia Duration \_\_\_\_\_

Due to Hypertensive Heart

Due to Chronic nephritis seven year

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) (e) Means of injury \_\_\_\_\_

23. Signature R. A. Bamberger (M. D. or other) \_\_\_\_\_

Address Madison, Mo. Date signed 6-27-41

SUPPLEMENTARY

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

MOTHER FATHER

S-15414