

FILED MAY 23 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15994

Registration District No. 812 Primary Registration District No. 6061 Registrar's No. 2

1. PLACE OF DEATH:

(a) County Scottland

(b) City or town Arbela

(c) Name of hospital or institution: Johnson

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Emma Laura Christy

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

4. Sex female race white 5. Color or race \_\_\_\_\_

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

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

7. Birth date of deceased June 8-1883

(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 10 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housekeeping

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

MOTHER FATHER { 12. Name John S. Hardy

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

MOTHER FATHER { 14. Maiden name Eveline Schmeider

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

16. (a) Informant Mrs. Velma Gutting

(b) Address Arbela Mo.

17. (a) Burial (b) Date thereof April 11-1941

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Revere Co.

18. (a) Signature of funeral director Gutting and

(b) Address Arbela Mo.

19. (a) 4/20/41 (b) OTM Baker and

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clark

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

(d) Street No. \_\_\_\_\_ (If rural, give location) 1

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9th 1941

year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from Feb 23, 1941, to April 10, 1941; that I last saw her alive on April, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Cervix

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

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

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

PHYSICIAN

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

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. L. McConell (M. D. or other) !!

Address Revere Mo Date signed \_\_\_\_\_

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

9  
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23  
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RECEIVED

District Health Officer No. 10

District File Number 5-41-9430

Date Filed MAY 14-1941

**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 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. 15994

Registration District No. 812

Primary Registration District No. 6061

Registrar's No.

1. PLACE OF DEATH:

(a) County Scotland  
(b) City or town Jehnsontown, Pa  
(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 Emma Laura Christy  
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 wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 6 - 8 - 1883  
(Month) (Day) (Year)

8. AGE: Years 57 Months 6 Days 1 If less than one day \_\_\_\_\_ 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

19. (a) 4/20/1941 (b) OTR Baker, MD  
(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 9  
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 \_\_\_\_\_

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

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

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? \_\_\_\_\_

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

23. Signature J. H. McConnell (M. D. or other) \_\_\_\_\_  
Address Reverse Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

S-15994