

S. No. 4-1
5-17

FILED MAY 13 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16003

Registration District No. 820 Primary Registration District No. 4496 Registrar's No.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Aran
(c) Name of hospital or institution: St. James
(d) Length of stay: In hospital or institution _____
In this community ✓
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott
(c) City or town Aran
(d) Street No. Rural
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Alice Marie
3. (b) If veteran, name war ✓ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 23
year 1941 hour 12 P.M. M.

4. Sex Fe! 5. Color or race Sw
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____

21. I hereby certify that I attended the deceased from Mar. 21, 1941, to March 31, 1941, that I last saw her alive on March 21, 1941, and that death occurred on the date and hour stated above.
Immediate cause of death Intestinal obstruction Duration ✓

8. AGE: Years 78 Months _____ Days 7 If less than one day _____ hr. _____ min.

Due to _____
Due to _____

9. Birthplace Johnson Co Arkansas
10. Usual occupation Housewife

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

11. Industry or business _____
12. Name Unknown
13. Birthplace _____
14. Maiden name Unknown
15. Birthplace _____

Major findings:
Of operations _____
Of autopsy _____

16. (a) Informant J. R. Davis
(b) Address Aran Mo
17. (a) _____ (b) Date thereof _____
(c) Place: burial or cremation Cremation

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director National Funeral Home
(b) Address Liberton Mo 630
19. (a) _____ (b) _____

23. Signature Edward H. Loest (M. D. or other) D.O.
Address Aran, Mo. Date signed 4-16-41

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

10
4
0

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

122B SEP 16 1941

RECEIVED

District Health Officer

District File Number 5415

Date Filed 9/18/41

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

Kenneth Jackson

Licensed Embalmer No. 3954

P. O. Address *Liberton, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 820

Primary Registration District No. 449L

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Oran
(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

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 _____

3. (a) PRINT FULL NAME Alice Davis

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: month Mar day 23
year 1947 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 _____ year

7. Birth date of deceased Feb 16 - 1884
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Intestinal Obstruction Duration _____

8. AGE: Years 78 Months - Days 7 If less than one day _____ hr _____ min

Due to _____

Due to _____

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

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

10. Usual occupation _____

Major findings: _____

11. Industry or business _____

Of operations _____

12. Name _____

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

Of autopsy _____

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

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

22. If death was due to external causes, fill in the following:

16. (a) Informant _____

(b) Address _____

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

(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? _____

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 Edward W. Faust (M. D. or other) MD

Address _____ Date signed _____

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

ROWENA WATSON

SUPPLEMENTARY

PHYSICIAN Underline the cause to which death should be charged statistically.

June 27, 1946

SEP 16 1941

Harry F. Parker, M. D.
Washington, D. C.

Dear Sir:-

I was called to see this patient March 21st 1941, the complaint being that patient had no bowel movement for 8 or 9 days. This patient had lain in bed during the past 7 or 8 years completely paralysed due to an attack of apoplexy. During this period of time great quantities of mineral oil were taken to produce bowel movement. Examination showed the rectum distended with a large mass of gummy feces, distending the anus. I removed a very great amount of this manually and made several unsuccessful attempts to pass a colon tube.

I believe the obstruction due to long continued accumulation of feces about the walls of the bowel, gradually filling the lumen until it finally closed off. When I saw the patient she was very weak and I considered her in a severe degree of retention toxicosis.

Sincerely yours,
Edward H. Lambert, M.D.

311-11-11

Registration District No. 820

Primary Registration District No. 4496

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Cran
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Sons Home
(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 Alice Davis

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 wid

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 76 Months - Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Johnson Co, Ark (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant J. R. Davis

(b) Address Cran _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Carpenters

18. (a) Signature of funeral director National funeral home

(b) Address Beverson _____

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 Mar day 23
year 1944 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 Intestinal obstruction Duration _____

Due to _____

Due to _____

Other conditions Senility
(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) (Means of injury)

23. Signature Edw H Laest (M. D. or other) _____

Address Cran _____ Date signed _____

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

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