

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural
(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 60 yrs.
(Specify whether years, months or days)
In this community 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
(c) City or town 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. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 26
year 1941 hour 4 minute 15 a. M.

21. I hereby certify that I attended the deceased from Dec 11
1940 to Dec 16 1940.
that I last saw her alive on Dec 16 1940.
and that death occurred on the date and hour stated above.

Immediate cause of death

Ovarian tumor, with
probable malignancy
Due to 49

Duration

not known

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 R. Q. Pitter, M.D. (M. D. or other)
Address Cape Girardeau, Mo. Date signed 3-1-41

3. (a) PRINT FULL NAME Ella Victoria McKinney

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Geo. McKinney 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased Dec. 12 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 14
If less than one day hr. min.

9. Birthplace Stoddard Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name John Sitton13. Birthplace Missouri
(City, town, or county) (State or foreign country)14. Maiden name Sarah Landreth15. Birthplace Waverly Tenn.
(City, town, or county) (State or foreign country)16. (a) Informant Geo. McKinney(b) Address Essex, Mo.17. (a) Burial (b) Date thereof 2/27/41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Bloomfield, Mo.
Blankenship-Strickland18. (a) Signature of funeral director
(b) Address Dexter, Mo.19. (a) (Date received local registrar)
(b) (Registrar's signature)

RECEIVED

District Health Officer No. 2,

District File Number 541-102

Date Filed 5-17-14

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. 3479

P. O. Address Weymouth, MA 0

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

16079

Registration District No.

839

Primary Registration District No.

6101

Registrar's No.

1. PLACE OF DEATH:

- (a) County Stoddard
(b) City or town Richland
(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

Elle Victoria McInerney

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 m

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

60

2

14

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date 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

NEAREST CERTIFICATION

20. DATE OF DEATH Month 2 day 26
year hour minute M.

21. I hereby certify that I attended the deceased from

that last saw h alive on
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
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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?

(Specify type of place)

While at work

(a) Means of injury

23. Signature R. Q. Ritter (M. D. or other)

Address Cape Girardeau Date signed 9/20

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

