

Registration District No. 138

Primary Registration District No. 5203

Registrar's No. 85

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Braymer, Washington
(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 1
In this community 1
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Carroll
(c) City or town Braymer
(If outside city or town limits, write "RURAL")
(d) Street No. U
(If rural, give location)
(e) If foreign born, how long in U. S. A. U years.

3. (a) PRINT FULL NAME Ada May Elder
(b) If veteran, name war --
(c) Social Security No. --

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 30
year 1941 hour 12: minute 50a. m.m.

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Johnnie T. Elder
6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased Jan. 12th, 1898
(Month) (Day) (Year)

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.

8. AGE: Years 43 Months 3 Days 18
If less than one day _____ hr. _____ min.

Immediate cause of death Brain tumor
Duration 3 yrs.

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

Due to _____
Due to _____

10. Usual occupation Housewife

Other conditions (include pregnancy within 3 months of death)
Epilepsy

11. Industry or business _____
12. Name Andy Fields
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Lucy Bailey
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Johnnie T. Elder
(b) Address Braymer, Missouri
17. (a) Burial (b) Date thereof May 1, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

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? 778

18. (a) Signature of funeral director Bernard T. Mead
(b) Address W. F. Braymer, Missouri
19. (a) May 1, 1941 (b) B. C. Cole
(Date registered) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature E. L. Smith, D.O. (M. D. or other) COR.
Address Carrollton, Mo. Date signed _____

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

700

1700

59A

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

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 *Bernard F. Neal*

Licensed Embalmer No. *2801*

P. O. Address *Baymer*

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

State File No. 17485-

Registration District No. 138

Primary Registration District No. 5203

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Washington Twp
(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 Carroll (b) County Carroll
(c) City or town Washington Twp
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ada May Elder
3. (b) If veteran, name war _____ (c) Social Security No. _____

20. DATE OF DEATH: Month Apr day 30
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.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

Immediate cause of death Brain tumor Dysarthria

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)

Due to epilepsy

8. AGE: Years 43 Months 3 Days 18 If less than one day _____ min.

Due to Tumor non malignant

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings: Of operations 54

11. Industry or business _____

Of autopsy _____

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

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. Smith (M. D. or other) _____
Address Carrollton Mo Date signed _____

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

SUPPLEMENTARY

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

MOTHER FATHER

