

FILED JUN 11 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18543

Registration District No. 608

Primary Registration District No. 5807A

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Newton  
 (b) City or town Stella  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Casswell Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 31 day years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry  
 (c) City or town R#1 Exeter  
 (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.? 1 years

3. (a) PRINT FULL NAME PLUT. HANNA ANTLE

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 Wayne Antle 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 20 1915  
 (Month) (Day) (Year)

8. AGE: Years 25 Months 10 Days 27 If less than one day hr. min.

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

10. Usual occupation Housewife

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

12. Name Otis M. Barton

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

14. Maiden name Elizabeth Barnum

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

16. (a) Informant Wayne Antle

(b) Address R#1 Exeter

17. (a) Removal (b) Date thereof 5-19-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newton Ark.

18. (a) Signature of funeral director John F. ...

(b) Address Casswell, Mo.

19. (a) 5-18-41 (b) Lida Collings  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from April - 1, 1941 to May 17, 1941; that I last saw her alive on May 17, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Placenta praevia Total 9 mo., shock & loss of blood.

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

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

Duration 9 mo., 9 mo., 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? \_\_\_\_\_

23. Signature Olar ... (Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

(b) Address Stella, Mo. (M. D. or other) \_\_\_\_\_ Date signed 5-18-41

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

MOTHER FATHER

1462

Path. Am.

RECEIVED

District Health Officer No. 6,

District File Number 641-914

Date Filed JUN 9 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 Eugene Wood

Licensed Embalmer No. 5804

P. O. Address Cassville, 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. 608

Primary Registration District No. 2807A

1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Newton  
(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 Ruth Anna Antle  
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 |
|         | <u>25</u> | <u>10</u> | <u>27</u> | 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 (Month) (Day) (Year)  
(Burial, cremation, or removal) (Month) (Day) (Year)

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 May day 17  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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 Placenta Praevia total  
Shock & loss of blood 9 min  
Due to delivery 1 hour before  
death

Other conditions (Include pregnancy within 3 months of death)  
Major findings: 1460  
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?

(Specify type of place) \_\_\_\_\_  
While at work? (e) Means of injury \_\_\_\_\_  
23. Signature C. Cardwell M.D. M. D. or other \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

S-18543 1941