

Registration District No. 714

Primary Registration District No. 5-943

Registrar's No.

1. PLACE OF DEATH:

(a) County Pulaski, Mo
(b) City or town Bloodland (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 _____ (Specify whether

In this community 43 years (Specify whether
years, months or days)

8. (a) PRINT FULL NAME Cora Agnes Firestine

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 Arthur Bert Firestine 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Feb 14 - 1877
(Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER { 12. Name William Hance
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Caroline Tucker
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Arthur B. Firestine

(b) Address Bloodland, Mo

17. (a) Burial (b) Date thereof May 25 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Palace Cem.

18. (a) Signature of funeral director J. L. Hoops & Sons

(b) Address Creeker, Mo

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski 85-
(c) City or town Bloodland (RURAL)
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h_____ alive on _____, 19____; 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 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? 642

While at work? _____ (Specify type of place) (d) Means of injury 9

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should underline the cause to which death should be charged statistically. AGE should be stated EXACTLY. PHYSICIANS should

RECEIVED

Pulaski County Health Officer

File Number 64117

Date Filed 6-13-41

2000

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. 18768

Registration District No. 714

Primary Registration District No. 5943

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pulaski
 (b) City or town Osney 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)

3. (a) PRINT FULL NAME Cora Agnes Firestone
 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 64 Months 3 Days 10
If less than one year _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) C. A. G. [Signature]
(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 24
 year 1947 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 Chronic Heart Trouble Duration _____
Valvular Heart Lesion _____
Rheumatism _____
 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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

958

PHYSICIAN

 Underline the cause to which death should be charged statistically.

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

S-18768 1941