

FILED JUN 19 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH19239
Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. 568
 (b) Township Sherrill Primary Registration District No. 6149
 (c) City _____ or _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Susie E. Edgar Case
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>W. D. Case</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 9, 1867</u>		
7. AGE	YEARS <u>74</u>	MONTHS <u>2</u>
	DAYS <u>17</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housework</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year) <u>July 1939</u>	
	11. Total time (years) spent in this occupation. <u>54</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Beulah, Mo</u>		
FATHER	13. NAME <u>James G. Marlow</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>	
MOTHER	15. MAIDEN NAME <u>Melvina Lane</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>	
17. INFORMANT (ADDRESS) <u>Willis Edgar Case</u> <u>Beulah, Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Beulah Cent</u> DATE <u>4-27-41</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Smith & Ferguson</u> <u>Beulah, Mo</u>		
20. FILED <u>7/26/41</u> 15 <u>77</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 26, 1941

22. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1941 to Apr 26, 1941.
 I last saw him alive on Apr 20, 1941. Death is said to have occurred on the date stated above, at 12:10 P.M.
 The principal cause of death and related causes of importance were as follows:
Pneumonia
1918
 Date of onset _____

Other contributory causes of importance:
Chronic nephritis

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? 24

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Dr. R. E. Reed M. D.
 (Address) Beulah, Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

I X18605

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 5,

District File Number 6411757

Date Filed

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. 19239

Registration District No. 868

Primary Registration District No. 6149

Registrar's No. 15

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Susie E. Edgar Chase

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 Months Days If less than one day
74 2 17 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 (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 5/26/8/14/11 (b) D. L. Reed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 26
year _____ 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 _____ 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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. L. Reed (M. D. or other) _____
Address Sherrill, Mo. Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

19239