

No. 2  
5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

19478  
State File No. ~~17154~~

FILED JUN 11 1941

Registration District No. 8 Primary Registration District No. 203 Registrar's No. 27

1. PLACE OF DEATH:  
(a) County Benton  
(b) City or town Justice  
(c) Name of hospital or institution: 1  
(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 Mo (b) County Benton  
(c) City or town Justice Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? NO - 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Naomi L. Day  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Apr day 3  
year 1941 hour 3 minute 00 M. a

4. Sex fr 5. Color or race wh  
6. (a) Single, widowed, married, divorced widow  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 4, 1865  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from  
April 1, 1941 to April 3, 1941  
that I last saw her alive on April 2, 1941  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
75 4 29 hr. \_\_\_\_\_ min.

Immediate cause of death Loss of vital force  
Due to Tuberculosis  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation Wife

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

MOTHER FATHER { 12. Name Low M. Swain  
13. Birthplace unknown Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Moore  
15. Birthplace unknown Mo  
(City, town, or county) (State or foreign country)

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?  
Yes (Specify type of place) \_\_\_\_\_ (e) Means of injury fall

16. (a) Informant Archie Day  
(b) Address Justice, Mo  
17. (a) burial (b) Date thereof 5/6/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Justice Cem

23. Signature J. W. Jolly (M. D. or other) J. W. Jolly  
Address Justice Date signed 4/14

18. (a) Signature of funeral director J. R. Luckey  
(b) Address Whitland, Mo  
19. (a) 5/21/41 (b) Jas. J. Logan  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

008

138

RECEIVED

District Health Officer No. 7,

Case File Number 6-41-957

Date Filed 6-9-41

*Large*

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

*J. P. Lueckey*

Licensed Embalmer No. 982

P. O. Address Sheffield

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.

Registration District No. 8 Primary Registration District No. 203 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Benton  
(b) City or town Frisco, T.P.  
(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 \_\_\_\_\_ (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 \_\_\_\_\_

3. (a) PRINT FULL NAME Naomi L. Day  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Apr. day 3  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;  
that I saw h. \_\_\_\_\_ 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 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)

Immediate cause of death Loss of vital force Duration \_\_\_\_\_  
Due to Tuberculosis  
Due to T.B. of lungs and bronchial tubes

8. AGE: Years Months Days . If less than one day  
75 - 4 29 hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
12/19  
Requested information

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) \_\_\_\_\_  
(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 W. J. Jolley & Co. (M. D. or other)  
Address Frisco, Mo. Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

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

19478