

FILED JUL 14 1941
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MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

21417
 Do not use this space.

1. PLACE OF DEATH

(a) County Clark Registration District No. 193
 (b) Township Deerbrook Primary Registration District No. 5270
 (c) City Waynes Rural (d) Street No. 8 Registered No. 970
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

(a) Residence, No. Kestank, R # 1 St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 7, 1920

7. AGE YEARS 20 MONTHS 11 DAYS 22 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Breaking eggs
 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) June 9, 1941 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Keosauqua, Ia

FATHER 13. NAME M. M. Eder

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

MOTHER 15. MAIDEN NAME Laura Bowers

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT Mrs. Laura Bowers (ADDRESS) Keosauqua, Ia

18. BURIAL, CREMATION, OR REMOVAL PLACE Removed DATE June 15, 1941

19. FUNERAL DIRECTOR C. R. Eder (ADDRESS) Keosauqua, Ia

20. FILED 6/19 1941 A. P. Kirchner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 15, 1941

22. I HEREBY CERTIFY, that I attended deceased from 19..... to June 15, 1941

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at 2:00 A.M.

The principal cause of death and related causes of importance were as follows:

Auto Accident
4 Highway, Osceola,
Iowa
Killed suddenly

Other contributory causes of importance:

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

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..... D.A.S.

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify (Signed) J. L. McCall M. D. (Address) Revere, Mo

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.

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RECEIVED

District Health Officer No. 10

District File Number 7-41-1215

Date Filed JUL 10 1941

STATEMENT BY LICENSED EMBALMER

I, C. Ryan, Licensed Embalmer No. 2202

hereby certify that the body recorded on the reverse side of this certificate ^{rel}embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed C. Ryan

Licensed Embalmer No. 2202

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21417

Registration District No. 193

Primary Registration District No. 5270

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clark

(b) City or town Des Moines 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 Laura Serena Eder

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 S

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>20</u>	<u>11</u>	<u>12</u>	hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 11 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.

Immediate cause of death auto accident Duration _____

Due to killed suddenly

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

1702

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) accident

(b) Date of occurrence June 15, 1941

(c) Where did injury occur? Des Moines Clark mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Stat Shopway No 61

While at work? _____ (Specify name of place) (e) Means of injury _____

23. Signature J. L. McDaniel (M. D. _____)

Address Revere mo. Date signed 8-16-41

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

SUPPLEMENTAL

