

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

28171

State File No.

Registrar's No.

Registration District No. 241

Primary Registration District No. 4147

1295

1. PLACE OF DEATH:

(a) County Dallas
 (b) City or town BUFFALO Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
BUFFALO Mo.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 (Specify whether
 In this community 1 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas 03
 (c) City or town BUFFALO Mo.
(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 12 day 30
 year 1941 hour 7 minute 15 P.M.
 21. I hereby certify that I attended the deceased from January
1st 1941 to 8-30 1941
 that I last saw her alive on 8-30 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 3 days
 Due to Arterio Sclerosis & Chronic renal disease 15 yrs
 Due to Chronic heart disease 5 yrs
 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. Blumner (M. D. or other) M.D.
 Address Buffalo Mo Date signed 9-4-41

3. (a) PRINT FULL NAME Mary Elizabeth Vinyard

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 W

6. (b) Name of husband or wife Geo. Vinyard 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 1 22 1862
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Keeper

11. Industry or business _____

12. Name Unknown

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 John Vinyard

(b) Address Buffalo Mo

17. (a) Burial (b) Date thereof 9-2-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buffalo

18. (a) Signature of funeral director L. B. Jones

(b) Address Buffalo Mo

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

215 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 7,

District File Number 9-41-1686

Date Filed 9-15-41

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

Clyde Montgomery

Licensed Embalmer No. 359

P. O. Address Buffalo Mo.

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.

No. 8
X29288

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28171

Registration District No. 241

Primary Registration District No. 4149

Registrar's No. 1295

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Buffalo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Buffalo Ins
(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

Mary E Vinyard

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

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

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

8-18-41
(Date received local registrar)

(b)

Harvey Moore
(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 12 Day 30
Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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)

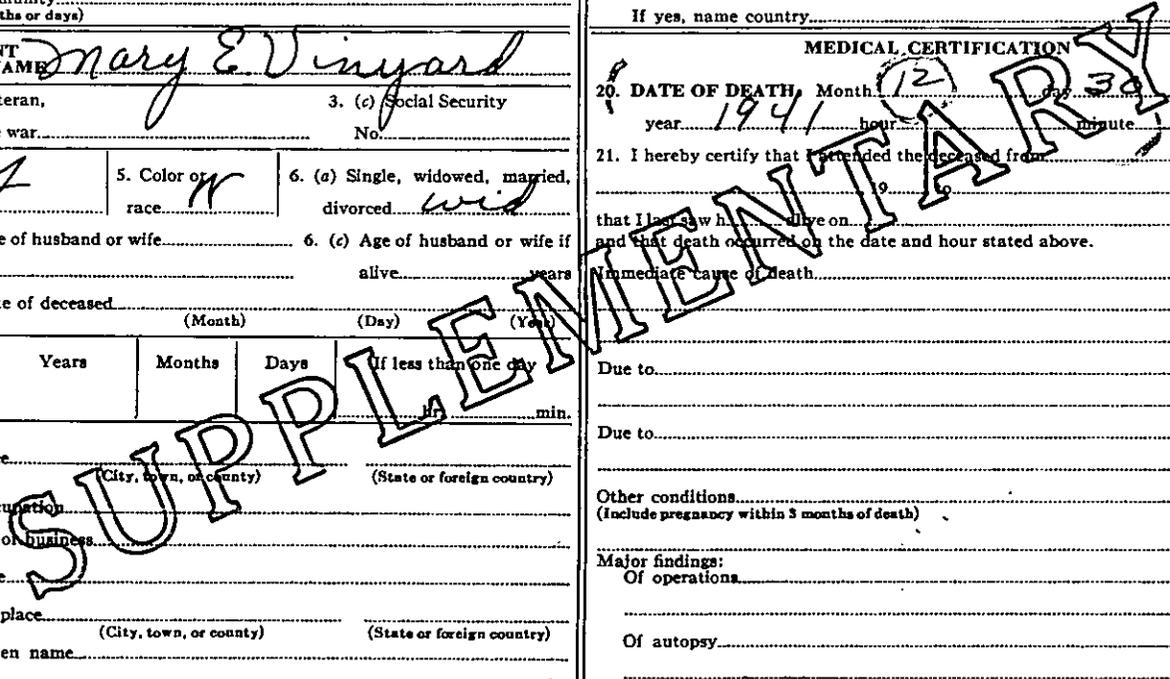
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

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

Address _____ Date signed _____

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



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100