

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29095

State File No. _____

Registration District No. 684

Primary Registration District No. 59.12

Registrar's No. 25

1. PLACE OF DEATH:
 (a) County Pike
 (b) City or town Rural-Cape Girardeau
 (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 90
 In this community 5-0 yrs.
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pike
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Near Vera
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Alice M. Spears
 8. (b) If veteran, name war No 8. (c) Social Security No. Pension
 4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 9
 6. (b) Name of husband or wife Wm Henry Spears 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 23-1898
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month AUG day 23rd year 1941 hour 11 minute PM.
 21. I hereby certify that I attended the deceased from _____, 1940, to _____, 19____;
 that I last saw her alive on AUG 23rd, 1941; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
83 2 0 hr. min.
 9. Birthplace D. K. Mississippi
 (City, town, or county) (State or foreign country)

Immediate cause of death HEART FAILURE
 Due to DIABETES 1923
CHR. NEPHRITIS
 Due to ARTERIO SCLEROSIS
 Other conditions _____
 (Include pregnancy within 3 months of death)

11. Industry or business _____
 12. Name D. K. Herin
 13. Birthplace _____
 (City, town, or county) (State or foreign country)
 14. Maiden name D. K.
 (City, town, or county) (State or foreign country)
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs Hersh Moore
 (b) Address Near Vera mo.
 17. (a) Burial (b) Date thereof Aug 25-1941
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Beeching Green Mo.
 18. (a) Signature of funeral director W. B. G. Moore
 (b) Address Beeching Green Mo.
 19. (a) 8-27-41 (b) W. B. G. Moore
 (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. B. G. Moore (M. D. or other) _____
 Address Beeching Green Mo. Date signed 8-25-41

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. 10

District File Number

9-41-1613

Date Filed

SEP - 8 1941

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

W. B. E. Moore

Licensed Embalmer No.

8464

P. O. Address

Bowling Green W.

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.

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State File No. 29095
Registrar's No.

Registration District No. 684 Primary Registration District No. 5912

1. PLACE OF DEATH:

(a) County Pike
(b) City or town 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 _____
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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 23
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I first saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

3. (a) PRINT FULL NAME Alicem Spears
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 _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 23 1853
(Month) / (Day) (Year)

8. AGE: Years 83 Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Barden Haven

13. Birthplace Don't Know (City, town, or county) (State or foreign country)

14. Maiden name Missouri Turner

15. Birthplace Don't Know (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) 27-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

Duration

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (c) Means of injury _____

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

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Wrote all this in 1941 at 27-41

Handwritten scribbles and illegible marks.

Handwritten scribbles and illegible marks.