

DEC 16 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39779

Do not use this space.

1. PLACE OF DEATH

(a) County Webster Registration District No. 900
(b) Township Union Primary Registration District No. 6207
(c) City (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 62 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Josephine Talbott 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 5 - 1861
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 3 26

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. Home
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation. life

12. BIRTHPLACE (CITY OR TOWN) Dallas Co., Mo.
(STATE OR COUNTRY) 0

13. NAME Solomon B. Conner

14. BIRTHPLACE (CITY OR TOWN) Tennessee
(STATE OR COUNTRY) 1

15. MAIDEN NAME Belinda Jane Wilkerson

16. BIRTHPLACE (CITY OR TOWN) Tennessee
(STATE OR COUNTRY) 1

17. INFORMANT A.W. Talbott
(ADDRESS) Niangue, Missouri.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Good Spring DATE November 2, 1941

19. FUNERAL DIRECTOR (NAME) Rev. Raine
(ADDRESS) Marshfield, Missouri.

20. FILED 19.....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 31, 1941

22. I HEREBY CERTIFY, That I attended deceased from Oct 1 - 1941, to Oct 31 - 1941

I last saw her alive on Oct 30, 1941. Death is said to have occurred on the date stated above, at 2 p.m.

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

Right. Lobes
Pneumonia
61

Date of onset

Other contributory causes of importance:
Acute Myelitis

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

Nature of injury

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

If so, specify

(Signed) W. F. Schmitt, M. D.

(Address) Niangue, MO

RECEIVED

District Health Officer No. 6,

District File Number 1241-1838

Date Filed DEC 11 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 _____

Licensed Embalmer No. 3312

P. O. Address Marshfield, 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, above space should be left blank.

Registration District No. 900

Primary Registration District No. 4207

Registrar's No. 1

1. PLACE OF DEATH:

(a) County W. Chester

(b) City or town Managers
(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 day(s)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Webster

(c) City or town Managers
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country Nation of State (Yes or No)
If year name country Spain + Mexico

3. (a) PRINT FULL NAME Josephine Salhans

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I have seen him/her live on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

4. Sex M 5. Color of race W

6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased: July 5, 1886
(Month) (Day) (Year)

8. AGE: Years 60 Months 3 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) Dec 9-47 (b) Haller Schleich
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

