

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3775

State File No. _____

FILED FEB 20 1942

Registration District No. 802

Primary Registration District No. 4484

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Schuyler
(b) City or town Lancaster Jun
(If outside city or town limits, write "RURAL" and name of township)
(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 80 (Specify whether years, months or days)
In this community 80 years, months or days

3. (a) PRINT FULL NAME JANE BODKINS

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

4. Sex female 5. Color of race white 6. (a) Single, widowed, married, 2 divorced, widowed

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

7. Birth date of deceased Nov. 19 1861
(Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation housewife

11. Industry or business Washington McClellan,

12. Name _____

13. Birthplace not known 9
(City, town, or county) (State or foreign country)

14. Maiden name Cynthia Newirk

15. Birthplace not known 9
(City, town, or county) (State or foreign country)

16. (a) Informant Sophia Nichols

(b) Address Lancaster Mo

17. (a) _____ (b) Date thereof Jan. 5, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 100F. Cemetery

18. (a) Signature of funeral director Moreheads

(b) Address Lancaster Mo

19. (a) Jan 9 42 (b) Byrdie H. Drake
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler's 98
(c) City or town Lancaster Mo 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3
year 1942 hour 11 minute 20 A. M.

21. I hereby certify that I attended the deceased from Jan 2 1942 to Jan 3 1942
that I last saw him alive on Jan 2 1942
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Myocardial Degeneration

Due to Senility

Due to _____

Other conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy 131 b

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 2

23. Signature R.E. Vaughn (M.D. or other) DO

Address Lancaster, Mo. Date signed 1-5-42

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

RECORD & VITALS BUREAU - MISSOURI DEPARTMENT OF HEALTH

1-13-40
2-17-40
1-13-40

MISSOURI DEPARTMENT OF HEALTH
BUREAU OF THE CORPUS

STANDARD CERTIFICATE OF DEATH

MISSOURI STATE BOARD OF HEALTH

State File No.

Register's No.

Primary Registration District No.

Registration District No.

1. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limit, write "RURAL")

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

(e) If foreign born, how long in U. S. A. _____ years

2. MEDICAL CERTIFICATION

3. DATE OF DEATH: Month _____ day _____

4. I hereby certify that I attended the deceased from _____ year _____ month _____ day _____ to _____ year _____ month _____ day _____

5. I certify that I last saw the deceased _____ day _____ month _____ year _____ and that death occurred on the date and hour stated above.

6. Immediate cause of death _____

7. Duration _____

RECEIVED

District Health Officer No. 10

District File Number 2-42-316

Date Filed FEB. 9 1942

1. PLACE OF DEATH:

(a) County _____

(b) City or town _____ (If outside city or town limit, write "RURAL" and name of township)

(c) Name of hospital or institution _____

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

(e) In this community _____ years, months or days

2. (a) PRINT FULL NAME _____

3. (a) II Vegetarian _____ (b) Social Security No. _____

4. Sex _____ Race _____

5. (a) Single, widowed, married, divorced _____

6. (a) Name of husband or wife _____ (b) Age of husband or wife _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____

9. Birthplace _____

10. PHYSICIAN _____

11. I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, working under my personal supervision.

12. 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 _____ (Specify type of place)

13. Other conditions _____

14. Major findings: _____

15. 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.)

16. If this body is not embalmed, fact should be so stated above.

10. Usual occupation _____

11. Industry or business _____

12. Birthplace _____ (State or foreign country)

13. Registered Apprentice No. _____

14. Signed _____

15. Licensed Embalmer No. 2731-3680

16. P. O. Address Lawrence, Mo.

17. (a) Address _____ (b) Address _____

18. (a) Address _____ (b) Address _____

(Licensed Embalmer's Statement on Reverse Side)