DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1942

Registration District No. 840

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3871

Primary Registration District No. 6102

Registrar's No. 2

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

1. PLACE OF DEATH

(a) County: Pemiscot Stoddard

(b) City or town: Puxico Mo

(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 ____ (Specify whether years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County: 103

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

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

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

8. (a) PRINT FULL NAME: Fannie Massey

8. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: F 1

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married 1

6. (b) Name of husband or wife: James Massey

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: Nov (Month) 4 (Day) 1886 (Year)

8. AGE: Years 56 Months 2 Days 19 If less than one day 4 hr. ____ min.

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

10. Usual occupation: House work

11. Industry or business ____

FATHER 12. Name: John Pratt

13. Birthplace: un known (City, town, or county) 9 (State or foreign country)

MOTHER 14. Maiden name: un known

15. Birthplace: un known (City, town, or county) 9 (State or foreign country)

16. (a) Informant: Lenard Walker

(b) Address: Puxico Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-19-42 (Month) (Day) (Year)

(c) Place: burial or cremation ____

18. (a) Signature of funeral director: Watkins Funeral

(b) Address: Puxico Mo Service

19. (a) 1-27-1942 (Date received local registrar) (b) J. P. Steinmeier (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 16 year 1942 hour 8 AM minute ____ M.

21. I hereby certify that I attended the deceased from Jan 9, 1942, to Jan. 16, 1942, that I last saw her alive on Jan 16, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia Lobar

Due to: Ischemia and Diabetes

Due to: ____

Other conditions (Include pregnancy within 3 months of death): 108

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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature: E. C. Masters (M. D. or other) M.

Address: Advance Mo. Date signed: Jan 24 1942

1130

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 2-42-201
Date Filed 2-10-42

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 B J Brentlinger
Licensed Embalmer No. 4201
P. O. Address Dexter, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3871

Registration District No. 840 Primary Registration District No. 6102 Registrar's No.

1. PLACE OF DEATH:
(a) County Ste Stoddard
(b) City or town Puxico
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Scoddard
(c) City or town Puxico, Rural
(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 Fanny Massey
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 4 (Day) 1886 (Year)
8. AGE: Years 56 Months 2 Days 5 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) 1-27-1942 (Date received local registrar) (b) J M Steinmeier (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 26 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY