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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

24750

State File No.

Registration District No. FILED AUG - 14 1942 200 Primary Registration District No. 5727 Registrar's No.

**1. PLACE OF DEATH:**

(a) County Macon

(b) City or town Excello-Mo RFD
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: [illegible]
None 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community lifetime years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Shelby 102

(c) City or town Excello Mo RFD 0
(If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME Nora Alice Cress

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race Whit

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

6. (b) Name of husband or wife Frank Cress

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased March (Month) 3 (Day) 1871 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 4 | 12 | 17 hr. 30 min. |

9. Birthplace Macon Co Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Ebenezer Enyart
13. Birthplace KY 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name don't know
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Opal Laytham
(b) Address Clo Enabel Mo

17. (a) 7/16-42 (Burial, cremation, or removal) (b) Date thereof 7/17-42 (Month) (Day) (Year)

(c) Place: burial or cremation Fair View

18. (a) Signature of funeral director Million & Barkelew
(b) Address Clarence Mo

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 14
year 1942 hour V minute M.

21. I hereby certify that I attended the deceased from July 1 1942 to July 14 1942
that I last saw her alive on July 13 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Pernicious Anemia

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death) 73a

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 0

23. Signature H. O. Newton (M. D. or other)

Address La Plata Mo Date signed 7/18/42

1001

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-42-1566
Date Filed AUG 12 1942

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 Henry G. Barkelew

Licensed Embalmer No. 3835

P. O. Address Shelbina, 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.**

V. S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 24750

Registration District No. 200 Primary Registration District No. 5727 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Macon
(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 years, months or days)
In this community Life

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

3. (a) PRINT FULL NAME Nora alice Cress
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 March (Month) 3 (Day) 1871 (Year)

8. AGE: Years 71 Months 4 Days 28 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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) 9/4/42 (Date received local registrar) (b) Nora B. Hinkle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him 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)
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY