

No. 2
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24937

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 10 1942

Registration District No. 633 20-4 Primary Registration District No. #382 58345-269 Registrar's No. _____

1. PLACE OF DEATH: Oregon Twp
 (a) County Thayer, Mo. Rural
 (b) City or town Thayer, Mo. Rural
 (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 60 years
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 75
 (a) State Mo. (b) County Oregon
 (c) City or town Myrtle, Mo.
 (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.? 0 years.

3. (a) PRINT FULL NAME Emma C. Stark

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

4. Sex female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased March 8 1955
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>11</u>	<u>21</u>	<u>✓</u> hr. <u>✓</u> min.

9. Birthplace Near Louisville, Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation School teacher

11. Industry or business farming in late years

12. Name Rowden Stark

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace ✓
(City, town, or county) (State or foreign country)

16. (a) Informant Osborne Cox

(b) Address Thayer, Mo. Star R.

17. (a) Burial (b) Date thereof Myrtle, Mo.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Myrtle, Mo.

18. (a) Signature of funeral director None
(b) Address _____

19. (a) 3-4-42 (b) Gae D. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year _____ 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.

Immediate cause of death _____
Senility -

Due to Verified by physician

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration
2 yr.

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 None (M. D. or other) _____

Address _____ Date signed _____

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

75
0
0

RECEIVED

District Health Officer No. 5,

District File Number 742467

Date Filed _____

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.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24937

Registration District No. 254

Primary Registration District No. 5867

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(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)

3. (a) PRINT FULL NAME Emma C Stack
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 S

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

7. Birth date of deceased Mar 8 1895
(Month) (Day) (Year)

8. AGE: Years 86 Months 11 Days 14 (If less than one day min.)

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

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) _____ (b) Date thereof 2 14 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Myrtle, Mo.

18. (a) Signature of funeral director None
(b) Address _____

19. (a) 3-4-42 (b) Geo O. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Oregon
(c) City or town Myrtle, Mo
(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 2-13 day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 19____
that I last saw him/her alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

*This woman simply died
due to the family buried her.
They had no coroner and
Dr. Cooper told me he had
attended her about a year before
other conditions her death. The family
turned it in to me a few
weeks after her death.*

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Geo O. Williams Registrar (M.D. or other)
Address Myrtle, Mo Date signed _____

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

SUPPLEMENTARY

