

FILED SEP 14 1942
Registration District No. _____

Primary Registration District No. 5564

Registrar's No. 60

1. PLACE OF DEATH:

(a) County IRON
(b) City or town "RURAL" ANNAPOLIS, W. VA.
(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 _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County IRON
(c) City or town ANNAPOLIS "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 EFFIE PEARL FANCHER.

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife YES 6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased July 17 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 0 4 hr. min.

9. Birthplace WAYNE COUNTY MO.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business W.

12. Name IRA CHARLETON.

13. Birthplace WAYNE CO MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name HANDY D. D.D.

15. Birthplace WAYNE CO MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant Jesse Fancher

(b) Address ANNAPOLIS, MO.

17. (a) BURIAL (b) Date thereof 7-21-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ANNAPOLIS CEMETERY

18. (a) Signature of funeral director See J. Fancher

(b) Address Iron, Missouri

19. (a) 8-10-42 (b) Virginia R. Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21
year 1942 hour 10:00 minute 25 A.M.
21. I hereby certify that I attended the deceased from July 20
1942, to July 21 1942
that I last saw her alive on July 20 1942
and that death occurred on the date and hour stated above.

Immediate cause of death uterine hemorrhage
Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

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 B. M. Fancher (M. D. or other) MD
Address Centerville Mo Date signed 7/21/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

47
00

1243

RECEIVED

District Health Officer No. 4
District File Number 942-1134
Date Filed 9-8-42

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.

Not Embalmed

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

Registration District No. 144

Primary Registration District No. 5564

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Iron
(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 Effie Pearl Fancher

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 W

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

7. Birth date of deceased July (Month) 17 (Day) 1906 (Year)

8. AGE: Years 38 Months 0 Days 0 If less than one day _____ 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) _____ (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) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ 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 slight hemorrhage

Due to Post Partum hemorrhage

Due to delivery of the child

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

146e

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

