

No. 2  
11-16-59  
5-17-39  
I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33169

FILED NOV 10 1942

State File No. \_\_\_\_\_

Registration District No. 36

Primary Registration District No. 4048

Registrar's No. 2

**1. PLACE OF DEATH:**  
 (a) County Boone,  
 (b) City or town Rocheport,  
(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 Boone  
 (c) City or town Rocheport  
(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.

8. (a) PRINTED FULL NAME Mrs Emma Haines,  
 9. (b) If veteran, name war \_\_\_\_\_ 9. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 2 Widowed,  
 6. (b) Name of husband or wife Nate Haines, 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased May-29th 1866  
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Missouri, \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home,

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Charles Canole,  
 13. Birthplace Missouri, \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 14. Maiden name Fanny Stapleton,  
 15. Birthplace Missouri, \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr W. E. Angel,  
 (b) Address Rocheport, Mo.

17. (a) Burial, (b) Date thereof 10-1st 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Rocheport Cem.

18. (a) Signature of funeral director Guy T. Halley.  
 (b) Address Fayette, Mo.

19. (a) Oct. 20 1942 (b) Mrs Betty Crane  
(Date received local registrar) (Registrar's signature)

878 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29  
 year 1942 hour 4 minute 10 P. M.

21. I hereby certify that I attended the deceased from July 10 1939 to Sept 29 1942  
 that I last saw him alive on Sept 26 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia secondary to arteriosclerosis

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) (e) Means of injury  
 23. Signature W. E. Angel (M. D. or other) \_\_\_\_\_  
 Address Rocheport, Mo. signed 10-1-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

100  
1-1  
1K

---

---

**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 Guy T. Haller  
Licensed Embalmer No. 2966  
P. O. Address Jayville 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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33169  
Registrar's No. 2

Registration District No. 36

Primary Registration District No. 4048

1. PLACE OF DEATH:

(a) County Beane  
(b) City or town Rockport  
(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)

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

Emma Hansen

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 \_\_\_\_\_

May 29  
(Month) (Day) (Year)

8. AGE:

Years 76

Months \_\_\_\_\_

Days \_\_\_\_\_

If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country) mo.

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) \_\_\_\_\_

(Date received local registrar)

(b) \_\_\_\_\_

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 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 Membrane

Due to arteriosclerosis  
chronic interstitial nephritis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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)

(b) 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 W. E. Russell (M. D. or other) \_\_\_\_\_

Address Rockport Mo Date signed 11-30-42

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

SUPPLEMENTARY

