

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 11 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 17

Registration District No. 60

Primary Registration District No. 5235

20
00

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

1. PLACE OF DEATH:

(a) County Cedar

(b) City or town Sheldon Star Route
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Seniors Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community all life to 2 or 3 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Cedar

(c) City or town Sheldon Star Route, Mo
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ella Jane Longbraker

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 22
year 42 hour 7:30 minute _____ M.

21. I hereby certify that I attended the deceased from 11-10 1942 to 11-22 1942
that I last saw her alive on 11-22 1942
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife SO Longbraker 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased 9 14 1882
(Month) (Day) (Year)

Immediate cause of death Bronchial pneumonia

Duration 107

Due to _____

Due to _____

8. AGE: Years 60 Months 2 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

Other conditions Asthma + Myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

MOTHER FATHER

12. Name John P. Dodd

13. Birthplace Indiana (City, town, or county) (State or foreign country) 1

14. Maiden name Sarah Bains

15. Birthplace Cedar Co. Mo (City, town, or county) (State or foreign country) 0

16. (a) Informant Tom Dodd

(b) Address Ferico Springs Mo.

17. (a) Burial (b) Date thereof 11-24-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. James Cemetery

18. (a) Signature of funeral director H. B. Blevins & Sons

(b) Address Sheldon Mo.

19. (a) Nov 24, 1942 (b) J. J. Schrock
(Date received local registrar) (Registrar's signature)

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? _____ (c) Means of injury 0

23. Signature J. P. Banister (M. D. or other) _____
Address Ferico Springs Mo. signed 11-23

RECEIVED

District Health Officer No. 7,

District File Number 12-42-1285

Date Issued 12-7-42

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.....

Gerald Beeny

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Gerald Beeny*

Licensed Embalmer No. 4203

P. O. Address. *Sheldon, 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.