

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

9815

FILED MAR 16 1943

## 1. PLACE OF DEATH

County ChristianRegistration District No. 50Township JacksonPrimary Registration District No. 4092City Linn Creek Mo.St. Mo. Ward 1

## 2. FULL NAME

(a) Residence, No. 1St. Mo.Ward 1

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widow

## 5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Wife

## 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

## 7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

86

## OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

none

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

## 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

## FATHER

## 13. NAME

Paul Lyon

## 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Ohio

## MOTHER

## 15. MAIDEN NAME

Dorah - Jean

## 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

## 17. INFORMANT (ADDRESS)

Verna Shuman (daughter)

## 18. BURIAL, CREMATION, OR REMOVAL

PLACE

St. Leon

DATE

2-271943

## 19. UNDERTAKER (ADDRESS)

Lon King

## 20. FILED

2-271943La Verna ShumanRegistrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH (MONTH, DAY, AND YEAR)

19

## 22. HEREBY CERTIFY That I attended deceased from

February 25, 1943, to February 26, 1943I last saw her alive on February 26, 1943 Death is saidto have occurred on the date stated above, at 10:00am.

The principal cause of death and related causes of importance were as follows:

Second degree Burn

Date of onset

1943

## Other contributory causes of importance:

noneName of operation none

Date of

What test confirmed diagnosis? None made as there an autopsy?

## 23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? accident Date of injury Feb 25, 1943Where did injury occur? St. Leon, Camden Co. Missouri

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

home

## Manner of injury

Burn

## Nature of injury

second degree burn24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed)

E. E. Blumhohl M.D.(Address) Camden, Missouri

RECEIVED

District Health Officer No. 7,

District File Number

Date Filed

2-43-98  
3-10-43

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9815  
Registrar's No. 11

Registration District No. 50

Primary Registration District No. 4072

1. PLACE OF DEATH:

- (a) County Camden  
(b) City or town Linn Creek  
(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 Abie Blind

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 \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 56 Months \_\_\_\_\_ Days \_\_\_\_\_ 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) \_\_\_\_\_ (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) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 Feb 26 1943  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_

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 \_\_\_\_\_

- 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 sta-  
tistically.

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?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

