

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

8660
Do not use this space.

FILED FEB 24 1944

1. PLACE OF DEATH *North Middlefork* Registration District No. *374*
 (a) County *North* Primary Registration District No. *6274*
 (b) Township *Middlefork*
 (c) City *North* (d) Street No. *1*
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *Effie May Cranor Canaday*
 (a) Residence, No. *113* St. *St.*
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *J. A. Canaday*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 1 1944*
 7. AGE YEARS *71* MONTHS *8* DAYS *-* LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housewife*
 9. Industry or business in which work was done, as saw mill, bank, etc. *same*
 10. Date deceased last worked at this occupation (month and year) *Nov 1943* 11. Total time (years) spent in this occupation *7 1/2*
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Stacyburg, Kentucky, Mo.*
 13. NAME *John H. Cranor*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Stacyburg, Mo.*
 15. MAIDEN NAME *Mary Bull*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Clinton, Ohio*
 17. INFORMANT (ADDRESS) *Iris Andrews North, Mo.*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Grain Chapel* DATE *1/14* 1944
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Walter Andrews North, Mo.*
 20. FILED *1-18* 1944 *Arlene Scadden* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 12 1944*
 I HEREBY CERTIFY, That I attended deceased from *Jan 1* 1944 to *Jan 12* 1944
 last saw him alive on *Jan 12* 1944 Death is said to have occurred on the date stated above, at *8:15* pm.
 The principal cause of death and related causes of importance were as follows:
Old age
Perforative Abdomen
 Date of onset *Jan 1*
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 Other contributory causes of importance
 Name of operation *None* Date of *None*
 What test confirmed diagnosis? *Autopsy* Was there an autopsy? *No*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *No* Date of injury *March 1944*
 Where did injury occur? *None* (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury *None*
 Nature of injury *None*
 24. Was disease or injury in any way related to occupation of deceased?
 If so, specify *John Andrews* M. D.
 (Signed) *John Andrews* (Address) *Grant City, Mo.*

1-16-44

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

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, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 374

Primary Registration District No. 6274

Registrar's No.

1. PLACE OF DEATH:

- (a) County Worth
(b) City or town Middlefork Twp.
(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 years, months or days)

3. (a) PRINT FULL NAME

Effie May C. Canady

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 m

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 19 years

7. Birth date of deceased Jan 4 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.

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

10. Usual occupation

11. Industry or business

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 (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 Jan year 1944 hour 12 minute 12 M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death old age

Diagnosis is abdominal

bowel malignancy

bowels 2 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 (M. D. or other)

Address Date signed

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

SUPPLEMENTAL

MAR

Ades