No. 2
-2-43
-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 10 1944

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 11143

Registration District No. 144 Primary Registration District No. 5562 Registrar's No. 11

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

**1. PLACE OF DEATH:**

(a) County Iron
(b) City or town Ariadia Rural or
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: The Home for Aged Baptists
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month - 8 days (Specify whether
In this community 1 month - 8 days
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Iron 47
(c) City or town Ariadia Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 1 mile East of Ariadia
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mary Sconce

3. (b) If veteran, name war ✓

3. (c) Social Security No. None

4. Sex Female | 5. Color or race White | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John H. Sconce

6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased February (Month) 16 (Day) 1865 (Year)

8. AGE: Years 79 | Months — | Days 27 | If less than one day ___ hr. ___ min.

9. Birthplace Randolph County, Ark (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business Her home

FATHER
12. Name Jesse M. Taylor
13. Birthplace — (City, town, or county) Alabama (State or foreign country)

MOTHER
14. Maiden name Tilda Justice
15. Birthplace — (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Jno. H. Burney
(b) Address Ironton, Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 3-17-44 (Month) (Day) (Year)
(c) Place: burial or cremation Eminence Mo.

18. (a) Signature of funeral director Norman White & Sons
(b) Address Ancel White Ironton Mo.

19. (a) ___ (Date received local registrar) (b) ___ (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar. day 14
year 1944 hour 5 minute 15 - P. M.

21. I hereby certify that I attended the deceased from March 6th 1944, to March 14th 1944,
that I last saw her alive on March 14, 1944
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death acute Bilateral Bronchial Pneumonia | 3/6/44 |
| Due to Influenza | 3/1/44 |
| Due to Senile Dementia | ? |
| Other conditions Cerebral Hemorrhage? (Include pregnancy within 3 months of death) | |

Major findings:
Of operations — 330
Of autopsy

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)
(d) 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 R. E. Harland (M. D. or other) M.D.
Address Ironton, Missouri Date signed 3-18-4

1365

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 444-36

Date Filed 4-7-44

**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 Ancel J. White

Licensed Embalmer No. 3012

P. O. Address Sarcoxie 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.**

No. 2B
—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 0

Registration District No. 144 Primary Registration District No. 5562 Registrar's No. 11

SUPPLEMENTARY

**1. PLACE OF DEATH:**
(a) County Dent
(b) City or town Rural Arcadia 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)
In this community

**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 Mary Scenne
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 years
7. Birth date of deceased Feb. 16 1865 (Month) (Day) (Year)

8. AGE: Years 79 Months — Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) Ark. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) March 19, 1944 (Date received local registrar) (b) Mrs. Francis E. Howard (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 14 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| 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 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? (Specify type of place)
While at work? (e) Means of injury

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

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