

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18397

State File No.

Registration District No. 1940

Primary Registration District No. 4246

Registrar's No. 11

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town CARL JUNCTION
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 504 LOCUST 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 Four Years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jasper

(c) City or town Carl Junction 49
(If outside city or town limits, write "RURAL")

(d) Street No. 504 Locust 3
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME AMANDA JANE Tweedy

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 SO

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

7. Birth date of deceased Nov 24 1956
(Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 28 If less than one day hr. _____ min. _____

9. Birthplace Edgar Co ILL
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Samuel Spence

13. Birthplace Rush Co Ind
(City, town, or county) (State or foreign country)

14. Maiden name Irene Revenagh

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs W.L. Tweedy

(b) Address Carl Junction Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-1944
(Month) (Day) (Year)

(c) Place: burial or cremation Carl Junction Cemetery

18. (a) Signature of funeral director Quey Funeral Service

(b) Address Carl Junction Mo

19. (a) May 25 1944 (Date received local registrar) Mrs Lillie Tagle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 23 day May
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Feb 4 1944 to May 23 1944
that I last saw her alive on May 24 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Bronchitis

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)

23. Signature D. L. Alberts (M. D. or other)

Address Carl Junction 23 Date signed 5/23/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

44-5-475-

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 J. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin 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.