

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *30380*

FILED OCT 11 1944

Registration District No. *1004*

Primary Registration District No. *1004*

Registrar's No. *239*

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Rural *Novinger*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home -- Novinger, R. R. No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether 1)
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Rosetta Bell Bragg

3. (b) If veteran, name war. _____ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Claudie R. Bragg 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Dec. 14 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 8 30 hr. min.

9. Birthplace Adair Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Campbell Hall

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

14. Maiden name Jane Campbell

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

16. (a) Informant Claudie Bragg

(b) Address Novinger, Mo.

17. (a) Burial (b) Date thereof 9/6/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Temple Cemetery

18. (a) Signature of funeral director Berkley
(b) Address Kirksville, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 4
year 1944 hour 3:20 minute A: M.

21. I hereby certify that I attended the deceased from February 23 1942 to Sept 2 1944
that I last saw her alive on July 15 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Urinary Bladder
Due to _____
Due to _____

Other conditions 52 f
(Include pregnancy within 3 months of death)

Major findings: autoscopic & biopsy - carcinoma
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 A. B. Crump (M. D. or other) _____
Address Kirksville Mo. Date signed 9-6-44

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

MOTHER FATHER

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-44-1206
Date Filed OCT 16 1944

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 *D. E. Riley*

Licensed Embalmer No. *4181*

P. O. Address *H. Kelle 2nd*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. OctRegistration District No. 1Primary Registration District No. 5004Registrar's No. 229

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Rural Finney
(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 days3. (a) PRINT FULL NAME Rosetta B. Biagg

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 See 14 18 70
(Month) (Day) (Year)8. AGE: Years 65 Months 8 Days _____ If less than one day _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) MO

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 19-6-44 (b) Mrs. J. P. Waggoner
(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 Oct year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

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? _____

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

SUPPLEMENTARY

30380