

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

No. 7  
-8-43  
5-17-39  
K37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6923

State File No.

FILED FEB 20 1945

Registration District No. 293

Primary Registration District No. 603

Registrar's No. 103

1. PLACE OF DEATH:

(a) County RR. RALLS  
 (b) City or town NEW LONDON  
(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 LIFE  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ralls 87  
 (c) City or town New London (Rural)  
(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 None

3. (a) PRINT FULL NAME MILDRED JO GENTRY HADEN

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 married  
 6. (b) Name of husband or wife EDGAR BAILEY HADEN  
 6. (c) Age of husband or wife if alive 56 years  
 7. Birth date of deceased AUG. 24 1889  
(Month) (Day) (Year)

8. AGE: Years 55 Months 4 Days 21  
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name William Joseph Gentry  
 13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Jucker Woodson  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. S. Jameson  
 (b) Address New London, Mo.

17. (a) Burial (b) Date thereof Jan 17 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Barkley Cem. New London Mo

18. (a) Signature of funeral director Frederick and Son  
 (b) Address Franklin Mo.

19. (a) 1-16-45 (b) R. B. Baking  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15  
 year 1945 hour 9 minute 0 M.  
 21. I hereby certify that I attended the deceased from Jan 1 1934 to Jan 15 1945  
 that I last saw her alive on Oct 15 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer  
 Duration 11 yrs

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: W. J. Waters  
 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 0

23. Signature W. J. Waters (M. D. or other) \_\_\_\_\_  
 Address New London, Mo. Date signed 1-16-45

1171

**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.....

*Jane Fields Megowan*

Licensed Embalmer No.....

*4093*

P. O. Address.....

*Frankford, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. MarchRegistration District No. 293Primary Registration District No. 6008Registrar's No. 103

## 1. PLACE OF DEATH:

(a) County Ralls - Co. Clay-Twp's  
(b) City or town New London Mo 69201  
(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 Mildred J. G. Haden

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.....

7. Birth date of deceased Aug 24 (Month) (Day) (Year)8. AGE: Years 55 Months 4 Days 4 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) (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 Jan Day 15 Year 1945 hour 10 minute 00 M.21. I hereby certify that I attended the deceased from 10 1945that I last saw h alive on 10 1945

and that death occurred on the date and hour stated above.

Immediate cause of death Right Breast Duration

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) (e) Means of injury.....

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

Address..... Date signed.....

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

SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

6923