

FILED OCT 18 1945

State File No.

Registration District No. 174

Primary Registration District No. 5644

Registrar's No. 41

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Lexington Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Sept 18 on the
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
 (c) City or town Rural Lexington Mo.
(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 Frances Fontaine Cantrell

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 Widowed
 6. (b) Name of husband or wife James E. Cantrell Deceased. 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased 8-6-1885 1885
(Month) (Day) (Year)

8. AGE: Years 60 Months 22 If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name William S. Fontaine
 13. Birthplace Lexington Mo. Rural
(City or town, or county) (State or foreign country)
 14. Maiden name Bettie Sanford
 15. Birthplace Weston Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Martha M. Fontaine
 (b) Address Kansas City Mo.

17. (a) 8-30-1945 (b) Date thereof Burrial
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Higginsville Mo.

18. (a) Signature of funeral director Edna H. Hauger
 (b) Address Higginsville. Mo.

19. (a) Oct-1-45 (b) Mrs. Fred Schuab
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August, day 28-1945
 year..... hour..... minute 00 P.M.
 21. I hereby certify that I attended the deceased from August 26, 1945
, 19....., to....., 19.....
 that I last saw h. or alive on August 26, 1945, 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Chronic myocarditis
 Due to Carcinoma of spine
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)

Duration
1 yr
 ?

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 E. M. Moore (M. D. or other)
 Address Higginsville, Missouri Date signed 8-29-45

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

RECEIVED

Health Officer No. 8;

District File Number.....

Date Filed 10-17-45

NOV 6 1945

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 Forrest A. Hooper

Licensed Embalmer No. 41358

P. O. Address Higginsville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1702

Registration District No. 174

Primary Registration District No. 5644

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Ruehl, Lexington Miss
(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

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 Francis J. Cantrell

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 WID

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 6
(Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____
If less than one day _____ hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business Homemaker

MOTHER FATHER

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 Alfred Hoefer

(b) Address Highway 100

19. (a) Oct 1 - 45 (b) Wm Ford Schaub
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration

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

Supplemental

By Wm Ford Schaub & Alfred Hoefer

34071