DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38726

FILED DEC 7 1945

Registration District No. 37

Primary Registration District No. 3112 C

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Illmo Rural Kelso 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
In this community 28 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott 100

(c) City or town Illmo Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. R1 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country ✓

3. (a) PRINT FULL NAME Martha Jane Curnell

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced Widow 3

6. (b) Name of husband or wife Alvin E Curnell

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

7. Birth date of deceased Oct (Month) 5 (Day) 1866 (Year)

8. AGE: Years 79 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace (City, town, or county) Ky 1 (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business ✓

FATHER
12. Name Harvey L Burns 9
13. Birthplace Don't Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Melvina Riley
15. Birthplace Don't Know (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs J W Broadhacker
(b) Address Illmo Mo R1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation Morley Cem Morley Mo

18. (a) Signature of funeral director Bisplinghoff Funeral Home
(b) Address Illmo, Mo

19. (a) 11-27-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26
year 1945 hour 1:00 minute 35 P M.

21. I hereby certify that I attended the deceased from July 2, 1945, to Nov 26, 1945;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death myocarditis	
Carcinoma (?)	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy none

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 A. E. Lee M.D. (M. D. or other)
Address Illmo Mo Date signed 11/27/45

724

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Office No. 2
District File Number 1245-3
Date Filed 12-3-45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Mamie Bisplinghoff

Licensed Embalmer No. 3245

P. O. Address Chaffee Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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. Dec

Registration District No. 330 Primary Registration District No. 3112C Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Illmo Rural Kelso 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 Martha J. Cunnell

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

7. Birth date of deceased Oct 5 1864 (Month) (Day) (Year)

8. AGE: Years 99 Months 1 Days Unless less than one day hr. min.

9. Birthplace (City, town, or county) Ky (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day Year 1945 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.

Immediate cause of death

Due to

Due to Primary site of Cancer unknown

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. E. Lee M.D. (M. D. or other)

Address Illmo Date signed 12/15/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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38726