No. 2
-2-43
-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

19374

State File No.

FILED JUN 20 1946

Registration District No. A

Primary Registration District No. 3000

Registrar's No. 169

1. PLACE OF DEATH

(a) County Adair

(b) City or town Kirksville Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Community Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days (Specify whether years, months or days)

In this community 17 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler Co.

(c) City or town Lancaster, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Gertrude Elizabeth Jeffries

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 Single

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased January (Month) 28 (Day) 1882 (Year)

8. AGE: Years 64 Months 4 Days 10 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name William C. Jeffries
13. Birthplace Schuyler Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Mary E. Williams
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bertha Jeffries
(b) Address Downing, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-46 (Month) (Day) (Year)
(c) Place: burial or cremation I.O.O.F. Cemetery Lancaster Mo

18. (a) Signature of funeral director Russell Denton
(b) Address Lancaster Mo.

19. (a) 6-12-46 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8 year 1946 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 22, 1946 to June 8, 1946 that I last saw him alive on June 8, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	1 day
Due to: Secondary carcinoma of lungs	Months
Due to: Osteogenic sarcoma of tibia	Months
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations

Of autopsy

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 a

23. Signature Harry R. Agnew (M. D. or other) D.O.

Address 100 N Walsh Kirksville, Mo. Date signed 6-8-46

(Licensed Embalmer's Statement on Reverse Side)

Officer No. 10

District File No. 6-46-1238

Date Filed JUN 18 1946

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~~ Burrell Benton, Registered Apprentice No. _____ working under my personal supervision.

Signed Burrell Benton

Licensed Embalmer No. 3705

P. O. Address Lancaster 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.

No. 2B
M—3-45
P1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July 1690

Registration District No. 1 Primary Registration District No. 2000 Registrar's No.

1. PLACE OF DEATH:

(a) County Adair (b) City or town Kirksville
(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

3. (a) PRINT FULL NAME Gertrude E. Jeffries

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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years

7. Birth date of deceased Jan (Month) 28 (Day) 1882 (Year)

8. AGE: Years 64 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) MO (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)

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 June 8 year 1946 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 — Duration

Due to Primary osteogenic sarcoma of tibia

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Harry R Agnew (M. D. or other) D.O.
Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

18250 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

19374