

REC'D MAR 15 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

6638
Do not use this space.

1. PLACE OF DEATH ²
(a) County Henry Registration District No. 347
(b) Township Clinton Primary Registration District No. 3018 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ella May Bixler
(a) Residence, No. North Water St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Adam Bixler
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 29 1896
7. AGE YEARS 42 MONTHS 5 DAYS 25 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House work
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-23 1939
22. I HEREBY CERTIFY, That I attended deceased from Oct 1938 to Feb 23 1939, 19____.
I last saw her alive on Feb 23 1939, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

Chronic myocarditis
930
Date of onset unknown

Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa
13. NAME James H Stark
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va
15. MAIDEN NAME Katherine Blymer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
17. INFORMANT (ADDRESS) E M Stark Clinton Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Englewood DATE 2/27 39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Consolidated Bk Clinton Mo
20. FILED 2-28 1939 D J R Hampton Local Registrar.

Name of operation none Date of _____
What test confirmed diagnosis clinical Was there an autopsy? no
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) S B Hughes, M. D.
Address Clinton, Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

RECEIVED

District Health Officer No.

District File Number 7-39-2

Date Filed 3-3-39

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 M. D. Snow

Licensed Embalmer No. 4034

P. O. Address Clinton, 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, above space should be left blank.