

Registration District No. 14

Primary Registration District No. 5496

Registrar's No. 30

1. PLACE OF DEATH:
 (a) County Henry
 (b) City or town Rural, Windsor Twsp.
 (c) Name of hospital or institution:
R # 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 50 years
 years, months or days

3. (a) PRINT FULL NAME Mrs. Eva Mae Dannatt

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 Widowed

6. (b) Name of husband or wife Hubert T. Dannatt 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 16, 1869
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>71</u>		<u>6</u>	_____ hr. _____ min.

9. Birthplace Happy Hollow Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Home maker

11. Industry or business _____

12. Name Robert Hazen

13. Birthplace unknown Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Hariett Farrer

15. Birthplace unknown unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Luther Farmer

(b) Address R # 2, Calhoun, Missouri

17. (a) Burial (b) Date thereof 11-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calhoun, Missouri

18. (a) Signature of funeral director Huston Turner

(b) Address Windsor, Missouri

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Henry
 (c) City or town R # 2, Calhoun, Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
0
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22
year 1940 hour 8:45 p m minute _____ M.

21. I hereby certify that I attended the deceased from Sept 22 1940 to Nov 22 1940
that I last saw her alive on Nov 22 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Capillary thrombosis of stomach

Due to _____
Due to 46

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? _____

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

23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed 11-23-40

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number 12-40-1787

Date Filed 12-13-48

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 me

RA Brauning

, Registered Apprentice No. 3377

working under my personal supervision.

Signed

RA Brauning

Licensed Embalmer No. 3377

P. O. Address Lecton, 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 CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38816

Registration District No. 14

Primary Registration District No. 3496

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Windsor 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 _____ 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) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Mrs. Evance Dammatt

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 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 _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 71 Months - Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (c) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 22 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 _____

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 R. J. Jennings (M. D. or other) _____

Address Windsor Twp Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

S-38816 - 1940