

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

Do not use this space.

35090

FILLED NOV 25 1941

1. PLACE OF DEATH

County Henry Registration District No. 347
 Township White Oak Primary Registration District No. 5495
 City Brick (No. _____) St. _____ Ward _____

File No. 18
 Registered No. _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 15 - 1869

7. AGE YEARS 72 MONTHS 11 DAYS 17 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as splinter sawyer, bookkeeper, etc. Housekeeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Own Home

10. Date deceased last worked at this occupation (month and year) 10-25-41 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Henry County, Mo.

13. NAME William Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

15. MAIDEN NAME Silina Teuberry

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

17. INFORMANT (ADDRESS) M. D. Smith, Brick, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Brick DATE 11-3-41

19. UNDERTAKER W. O. A.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 2, 1941

22. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1941, to Nov. 2, 1941

I last saw her alive on Nov. 2, 1941. Death is said to have occurred on the date stated above, at 10:50 a.m.

The principal cause of death and related causes of importance were as follows:

Tobacco poisoning
Decompensated Heart
Stagnant blood

Other contributory causes of importance: 106

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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 _____

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

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....,St.Ward)

2. FULL NAME.....

(a) Residence, No..... St..... Ward.....
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word).....

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF.....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR).....

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
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OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....	11. Total time (years) spent in this occupation.....
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....	
	10. Date deceased last worked at this occupation (month and year).....	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

13. NAME.....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

15. MAIDEN NAME.....

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL
 PLACE..... DATE....., 19.....

19. UNDERTAKER (ADDRESS).....

20. FILED..... 19.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)....., 19.....

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....
 I last saw h..... alive on....., 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:

RECEIVED
 District Health Officer No. 7,
 District File Number 11-41-192-3
 Date Filed 11-24-41
 Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

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)....., M. D.
 (Address).....

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35090
Registrar's No. _____

Registration District No. 347

Primary Registration District No. 5495

1. PLACE OF DEATH:

- (a) County Henry
- (b) City or town Urich
(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)

3. (a) PRINT FULL NAME

Susie E. Depew

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

6. (e) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Nov 15
(Month) (Day) (Year)

8. AGE:

Years 71

Months 11

Days _____

(If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director W. J. Brown

(b) Address _____

19. (a) Nov. 4, 1941

(Date received local registrar)

(b) Dr. J. R. Hampton

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County _____
- (c) City or town Urich
(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 Nov Day _____ Year 1941 hour _____ minute _____ M.

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

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

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? _____

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

SUPPLEMENTARY

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