JAN 14 1939

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

1707
Do not use this space.

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

1. PLACE OF DEATH
(a) County ~~Platte~~ Buchanan Registration District No. 83
(b) Township Crawford Primary Registration District No. 5124 Registered No.
(c) City Wallace Mo (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 Cynthia Postom
(a) Residence, No. St. Wallace, Missouri
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 William Postom

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) February 17, 1861

7. AGE: Years 77 | Months 10 | Days 17 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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

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

FATHER
13. NAME James Meek
14. BIRTHPLACE (CITY OR TOWN) Elkhart
(STATE OR COUNTRY) Indiana

MOTHER
15. MAIDEN NAME Cynthia Boyle
16. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Ohio

17. INFORMANT George Meek
(ADDRESS) Dearborn, Missouri

18. BURIAL, CREMATION, OR REMOVAL
PLACE Juda Cemetery DATE January 7, 1939

19. FUNERAL DIRECTOR (NAME) Walter Meierhoffer
(ADDRESS) 1302 Faraon Sts. St. Joseph, Mo.

20. FILED 1/5 1939 Mrs L Hull
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 8, 1938, to Jan 4, 1939
I last saw her alive on Jan 4, 1939 Death is said to have occurred on the date stated above, at 11:40P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	1/2/39
Chronic myocarditis	?
Malignancy of digestive tract & peritoneum	

Other contributory causes of importance:
Arteriosclerosis

Name of operation none Date of
What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? none 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 none
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) R J Felling M.D.
(Address) Weston, Missouri.

Licensed Embalmer's Statement on Reverse Side)

4

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, Yes

Wilbur H. Kelly, or by

Registered Apprentice No....., working under my personal supervision.

Signed Wilbur H. Kelly

Licensed Embalmer No. Mo. 3946

P. O. Address 1302 Faraon Sts. St. Jo

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

If this body is not embalmed, above space should be left blank.

7

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan Registration District No. 83
(b) Township Crawford Primary Registration District No. S124 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 Cynthia Pastom
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
77	10	17	

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

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

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 – 4, 1939

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:

Date of onset

Broncho Pneumonia
Chronic myocarditis, malignancy of digestive tract and peritoneum

Other contributory causes of importance:
Arterio Sclerosis
Primary seat of Mal. in Liver

46

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) R. J. Felling, M. D.
(Address)

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SMALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.