

1939 MAR 15 1939

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

5758  
Do not use this space.

1. PLACE OF DEATH  
(a) County Audrain Registration District No. 921  
(b) Township Cairo Primary Registration District No. 45371  
(c) City Farber, Mo. (d) Street No. \_\_\_\_\_  
(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 Lydia Ellen Pence  
(a) Residence, No. 353718 Washburn St.  Chicago Ill  
(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) married  
6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF H. S. Pence  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 24 - 1869  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 69 3 12  
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. Home  
10. Date deceased last worked at this occupation (month and year) Feb 25 - 1939 11. Total time (years) spent in this occupation LIFE  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Barry Ill  
13. NAME W. H. Boulden  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known  
15. MAIDEN NAME Rebecca Jane Taylor  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known  
17. INFORMANT H. S. Pence (ADDRESS) Chicago Ill  
18. BURIAL, CREMATION, OR REMOVAL PLACE Chicago Ill DATE Mar 8 1939  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. G. Granger  
Ladonia, Mo.  
20. FILED Mar 14 1939 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 8 1939  
22. I HEREBY CERTIFY, That I attended deceased from March 1 1939 to March 8 1939  
I last saw h. or alive on March 7 1939 Death is said to have occurred on the date stated above, at 3 A. m.  
The principal cause of death and related causes of importance were as follows:  
Apoplexy Date of onset March 1 - 39  
Other contributory causes of importance:  
Arterio-Sclerosis and Brights disease of kidneys  
Name of operation \_\_\_\_\_ 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? No.  
If so, specify \_\_\_\_\_  
(Signed) Wm. M. Walsh, M. D.  
(Address) Ladonia Mo.

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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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, .....

*H. G. Granger*

or by .....

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

Signed *H. G. Granger*

Licensed Embalmer No. *1297*

P. O. Address *Ladonia, 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.

EMBALMER'S CERTIFICATE

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

5758  
Do not use this space.

1. PLACE OF DEATH

(a) County Anderson Registration District No. 921  
 (b) Township \_\_\_\_\_ Primary Registration District No. 45-5-7  
 (c) City Ferber (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 Lydia Ellen Pence

(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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>63</u>	MONTHS <u>9</u>	DAYS <u>12</u>	If LESS than 1 day, _____ hrs. or _____ min.
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____				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-8-1939

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:

apoplexy

Date of onset \_\_\_\_\_

Other contributory causes of importance:  
arterio sclerosis and Bright's Disease of kidneys Chronic

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) W. K. McCall, M. D.  
 (Address) Ladonia Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 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.

Local Registrar.

