

80

REC'D APR 19 1939

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

11574
Do not use this space.

1. PLACE OF DEATH

(a) County Miller Registration District No. 5-67
(b) Township Franklin Primary Registration District No. 5-75-6
(c) City Eldon (d) Street No. _____ Registered No. 19
(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 Mary Jane Strange

(a) Residence, No. _____ St. (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 Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 1 1885
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
53 5 6

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. housewife
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) Missouri

13. NAME Clark Wallace

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Missouri

15. MAIDEN NAME Joan Buchannan

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

17. INFORMANT Effie Bailey (ADDRESS) Ulman, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Dooley DATE Mar. 9-1939

19. FUNERAL DIRECTOR (NAME) Phillips Funeral Home (ADDRESS) Eldon, Missouri

20. FILED 4-9-39 Belle Hayes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 7-1939

22. I HEREBY CERTIFY, That I attended deceased from 3-1-39 to 3-7-39. I last saw him alive on 3-6-39. Death is said to have occurred on the date stated above, at 4: P.M.
The principal cause of death and related causes of importance were as follows:

Bronchopneumonia
Bilateral
72

Date of onset 2-28-39

Other contributory causes of importance: Pulmonary Th

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 _____
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) E. C. Shelton, M. D.
Eldon 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.

RECEIVED

Miller County Health Dep't

County File Number 39-40

Date Filed 4-12-39

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,

Louis D. Phillips

or by

Registered Apprentice No., working under my personal supervision.

Signed

Louis D. Phillips

Licensed Embalmer No. 3663

P. O. Address

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.