

REC'D APR 7 1939

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

12055
Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 743
(b) Township Johnson Primary Registration District No. 6237 Registered No. 5
(c) City Ray (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

(a) Residence, No. 2 miles W. Rayville Mo. (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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 11 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 0 28

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. Home
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 Joseph Thompson

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

15. MAIDEN NAME Sultania Holman

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

17. INFORMANT (ADDRESS) Miss Mattie Teegarden
Rayville Mo.

18. BURIAL, CREMATION OR REMOVAL PLACE Union County DATE 3-10 - 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) James A. Moles
Lawson Mo.

20. FILED Mar. 12, 1939 Blount, Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 9, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 6, 1939, to Mar 8, 1939
I last saw her alive on Mar 8, 1939 Death is said to have occurred on the date stated above, at 12:30 A. m.

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

Bronchial Pneumonia Date of onset 3/5/39
Influenza

Other contributory causes of importance: 11/11

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 occupation of deceased? No

If so, specify _____ (Signed) John J. Grace M. D.

(Address) Excelsior Springs, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
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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STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
BUREAU OF HEALTH CARE LICENSING

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

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

Signed

James A. Moles

Licensed Embalmer No. *3296*

P.O. Address *Lawson 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.