

MAY 12 1939

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

14757
Do not use this space.

1. PLACE OF DEATH *Dent*

(a) County *Dent* Registration District No. *266*

(b) Township *Springcreek* Primary Registration District No. *0370* Registered No. *29*

(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 *Shirley Mae Rictor*

(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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Mar 7-1939*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
			<i>25</i>	

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

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) *Dent Co Mo.*

FATHER 13. NAME *Frank Rictor*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Dent Co Mo.*

MOTHER 15. MAIDEN NAME *Ethel Padesch*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Dent Co Mo.*

17. INFORMANT (ADDRESS) *Frank Rictor Salem Mo R 1*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Round Bend* DATE *4/12* 1939

19. FUNERAL DIRECTOR (ADDRESS) *H. D. Johnson Salem Mo.*

20. FILED *April 1, 1939* *A. E. Butler, M.D.* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from *March 31*, 1939, to *March 31*, 1939.

I last saw her alive on *March 31*, 1939. Death is said to have occurred on the date stated above, at *12:45* p.m.

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

broncho pneumonia

Date of onset *3/26/39*

Other contributory causes of importance:

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) *E. E. Jeffery*, M. D.
Salem, Mo. (Address) *246*

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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107a

STATEMENT BY LICENSED EMBALMER

I, N. D. Hobson, Licensed Embalmer No. 928

hereby certify that the body recorded on the reverse side of this certificate was embalmed by ^{not} as all

..... L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed N. D. Hobson

Licensed Embalmer No. 928

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.)

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH OFFICERS
MEMPHIS, TENNESSEE

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

14757
Do not use this space.

1. PLACE OF DEATH

(a) County Deer Registration District No. 266
 (b) Township Spring Creek Primary Registration District No. 5390
 (c) City..... (d) Street No..... Registered No. 29
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Shirley Mae Rictor

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (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.
25

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) 4/1 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:

Broncho pneumonia Date of onset

Other contributory causes of importance: None

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) G. E. Joseph, M. D.

(Address) Salem, Mo

SUPPLEMENTARY

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.

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

