REC'D JUN 14 1939

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

19279
Do not use this space.

1. PLACE OF DEATH
(a) County Montgomery — Registration District No. 593
(b) Township Danville — Primary Registration District No. 4351 — Registered No. 75
(c) City New Florence 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 Mrs Ora Maude Cardwell
(a) Residence, No. Life St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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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 T.L. Cardwell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec I st 1866

7. AGE — YEARS 72 — MONTHS 5 — DAYS 17 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home
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) New Florence Mo 0

FATHER
13. NAME D.D. Robinson 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentuckey 0

MOTHER
15. MAIDEN NAME Kathryn Loyd
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Florence Mo

17. INFORMANT (ADDRESS) Miss Kathryn Cardwell New Florence Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE New Florence Cem DATE 5/20/39, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. W. Hop,kins Montgomery City Mo

20. FILED 6/10, 1939 James O. Helm
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/18/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 4-1, 1939, to 5-10, 1939
I last saw her alive on 5-10-, 1939. Death is said to have occurred on the date stated above, at 3 37 m. Pm
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchial pneumonia	5-8-39
Cerebral Haemorrhage	5-1-39
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Other contributory causes of importance:	
Instituial Nephritis 1936	36-
Hypertension	36-

Name of operation ..... Date of .....
What test confirmed diagnosis? Lab & Chem 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) James O. Helm, M. D.
523 (Address) New Florence Mo

(Licensed Embalmer's Statement on Reverse Side)

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, on the 18 th day of May 1939, or by _____,

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

Signed _____

Licensed Embalmer No. 1487

P. O. Address Montgomery City 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.