

DEC'D JUL 10 1939

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

21203
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1602 Registered No. 2471
 (c) City Pennsac City (d) Street No. St. Marys Hospital 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 ALLIE PICKERING

(a) Residence, No. 265 (Usual place of abode, if no street address, write county or city) St. Richmond Missouri
 (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) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF X Unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
72 X X X X
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House duties
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 18, 1939
 22. I HEREBY CERTIFY, that I attended deceased from June 3, 1939 to June 18, 1939
 I last saw her alive on June 18, 1939 Death is said to have occurred on the date stated above, at 7:20 P.M.
 The principal cause of death and related causes of importance were as follows:

Chronic Cholelithiasis
Cholelithiasis
Post-operative shock
 Date of onset 126

Other contributory causes of importance:
 Name of operation Cholecystectomy Date of 6/13/39
 What test confirmed diagnosis? X-ray 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?
 If so, specify _____
 (Signed) Edward P. Ponder, M. D.
 (Address) St. Marys Hospital

12. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Unknown 9
 13. NAME Unknown 9
 14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Unknown 9
 15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Unknown
 17. INFORMANT Mrs. H. D. Magill (ADDRESS) Richmond Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Richmond DATE June 20, 1939
 19. FUNERAL DIRECTOR (NAME) E. Thurman (ADDRESS) 618 39th St. N. Grove
 20. FILED 1939 Local Registrar.

WHITE 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.

1 X14023

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.....

Licensed Embalmer No.....

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.