

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.

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

26377  
 Do not use this space.

AUG 11 1939

**1. PLACE OF DEATH**

(a) County Newton Registration District No. 615  
 (b) Township Marion Primary Registration District No. 5817 Registered No. 18  
 (c) City \_\_\_\_\_ (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**

Mertina Estelle Camerer  
 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles H. Camerer  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 1, 1872  
 7. AGE YEARS 66 MONTHS 11 DAYS 26 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 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) Fayette Wisconsin

**FATHER**  
 13. NAME Harve B. McDaniel

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

**MOTHER**  
 15. MAIDEN NAME Martha J. Cross

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fayette Wisconsin

17. INFORMANT (ADDRESS) L. E. Camerer R#1 Granby, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Crouch Cem DATE July 29 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Roy General Home Cassville Mo.

20. FILED 7-24 1939 Mrs. U. S. Chapman Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 27 1939  
 22. I HEREBY CERTIFY That I attended deceased from June 15 1939 to July 27 1939  
 I last saw her alive on July 20 1939. Death is said to have occurred on the date stated above, at 8:30 a.m.  
 The principal cause of death and related causes of importance were as follows:

Gastric Ulcer  
 Date of onset \_\_\_\_\_  
1170  
 Other contributory causes of importance: Jejunum

Name of operation None 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 X  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) J. W. Langley, M. D.  
 (Address) Box 94 Granby Mo.

RECEIVED

District Health Officer No. 6,

District File Number *839-1523*

Date Filed *AUG 8 1939*

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,

*Eugen Wood*

or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Eugen Wood*

Licensed Embalmer No.

*3804*

P. O. Address

*Cassville, 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.