

AUG 3 1939

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

27013  
Do not use this space.

1. PLACE OF DEATH  
(a) County Stoddard Registration District No. 840 451  
(b) Township Duck Creek Primary Registration District No. 10102 Registered No. 22  
(c) City Pupco (d) Street No. Sub 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. How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Frances Jearldian Cade  
(a) Residence, No. \_\_\_\_\_ St.  (If no street address, write county or city)  
(If no resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Baby  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7.31.39  
7. AGE YEARS MONTHS DAYS 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. \_\_\_\_\_  
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) Pupco Missouri

FATHER 13. NAME Maad Clay Cade

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

MOTHER 15. MAIDEN NAME Lilly May Warr

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne County Mo.

17. INFORMANT (NAME) (ADDRESS) Jones Paney  
Spring, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pupco Cemetery DATE 7.31.39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John

20. FILED 7-31-39 Deanna Dyeat Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7.31.1939  
22. I HEREBY CERTIFY, That I attended deceased from 7.31.1939, to 7.31.1939  
I last saw her at Stollon 7-31-1939 Death is said to have occurred on the date stated above, at 2:00 P.M.  
The principal cause of death and related causes of importance were as follows:

Transverse position  
Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Extra large skull  
Protruding labor

Name of operation section Date of 7.31.39  
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?  
If so, specify \_\_\_\_\_  
(Signed) Dr. John H. Yehli D.  
Harrod, 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.

FORM-1-12-38 I X14035

RECEIVED

District Health Officer No. 2,

District File Number 839107

Date Filed 8-2

**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.**