

SEP 1 1939

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

28970
Do not use this space.

1. PLACE OF DEATH

(a) County Cooper Registration District No. 24
(b) Township Otterville Primary Registration District No. 4194 Registered No. _____
(c) City Otterville or _____ (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 2 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

401 Malinda Hopper Cahal
(a) Residence, No. Otterville Mo. 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 (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. C. Cahal
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 22, 1877
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
62 1 23
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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

OCCUPATION

FATHER

MOTHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Columbus, Kansas
13. NAME J. C. Chasey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
15. MAIDEN NAME Kathleen Miller
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana
17. INFORMANT (ADDRESS) Mrs. Rev. Snapp, Otterville, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Gravolia no. DATE 8-17-39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Parker Funeral Service, Otterville, Mo.
20. FILED 8/20 19 39 Robt H. Fogel Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-15-39

22. I HEREBY CERTIFY, That I attended deceased from 8/15, 1939, to 8/15, 1939

I last saw him alive on 8/15, 1939. Death is said to have occurred on the date stated above, at 6 a.m.

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

Acute dilation heart
Pulmonary Haemorrhage
Date of onset 8/10
7.0

Other contributory causes of importance:

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 _____, 1939

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) Robt H. Fogel, M. D.

(Address) Otterville, 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.

22

RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE 9/1/37

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.....

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

Signed L. F. Parker
Licensed Embalmer No. 3840
P. O. Address Ottawa, Ill.

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.

11111

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28970
Do not use this space.

1. PLACE OF DEATH

(a) County Cooper Registration District No. 221
(b) Township _____ Primary Registration District No. 4134 Registered No. _____
(c) City Otterville (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 Malinda Hopper Cabal

(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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. or _____ min.
62 1 23

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) 8-15-39

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I first 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:

acute dilatation heart
prob. coronary thrombosis
heart thrombosis
was dying when I saw her
Other contributory causes of importance:

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 _____ M. D.

(Signed) Robert Fogle _____
(Address) Otterville _____

SUPPLEMENTARY

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

S-28970