

1939 OCT 12 1939

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

32515
Do not use this space.

1. PLACE OF DEATH

(a) County **Howard**,² Registration District No. **378**
 (b) Township **Fayette**,¹ Primary Registration District No. **4222**
 (c) City **Fayette**, (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 **Charles Fletcher Todd**

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male**
 4. COLOR OR RACE **White**
 5. SINGLE, MARRIED, WIDOWED, OR **Married**
 DECEASED (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9. 11th 1939**, 19

5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF **Ida Payne Todd**,
 (OR) WIFE OF

I HEREBY CERTIFY, That I attended deceased from **July 15**, 19**39**, to **Sept 4**, 19**39**
 I last saw him alive on **9-10**, 19**39**. Death is said to have occurred on the date stated above, at **2:4** m.
 The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **7/1st 1878**

Coronary occlusion 9-10-39

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 2 10

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At Home**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Farmer**
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

Other contributory causes of importance:
Chc. Cardio-Vascular 1938
Renal disease
Fracture of left Hip July 1939

12. BIRTHPLACE (CITY OR TOWN) **Missouri**,
 (STATE OR COUNTRY)

FATHER
 13. NAME **Neriah Todd**

14. BIRTHPLACE (CITY OR TOWN) **Missouri**,
 (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME **Mary Aflick**

16. BIRTHPLACE (CITY OR TOWN) **Virginia**,
 (STATE OR COUNTRY)

17. INFORMANT **C.F. Todd**
 (ADDRESS) **Fayette, Mo.**

18. BURIAL, CREMATION, OR DISPOSAL PLACE **Walnut Ridge**, DATE **9/12th 1939**

19. FUNERAL DIRECTOR (NAME) **Guy T. Halley**,
 (ADDRESS) **Fayette, Mo.**

20. FILED **Oct 5 1939** **V. C. Bonham**
 Local Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? **None** Was there an autopsy? **NO**

22. 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) **Joe Bloom**, M. D.
 (Address) **Fayette Mo**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1948
10/2/39

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 10/2/39

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32575-9
Do not use this space.

1. PLACE OF DEATH

(a) County Howard Registration District No. 378
 (b) Township _____ Primary Registration District No. 4227 Registered No. _____
 (c) City Fayette (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

Charles Fletcher Todd
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 (write the word)

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.
61 2 10

OCCUPATION 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) 9-11, 1937

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

I last 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:

Cerebral occlusion
1560
 Date of onset

Other contributory causes of importance:

Chr Cardio Vascular
Renal Disease
Fracture left hip

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 7-5, 1939

Where did injury occur? Home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall

Nature of injury Fracture left hip

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) M. A. Bloom, M. D.

(Address) Fayette Mo

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

