

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

32523

Do not use this space.

1. PLACE OF DEATH

- (a) County Howell Registration District No. 385
 (b) Township Faldsberry Primary Registration District No. 33-3-4
 (c) City Minerva Mo. (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

- (a) Residence, No. 213 North McFadden St. (If nonresident, give city or town and State)
Minerva Mo.
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> <small>(write the word)</small>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>Wess McFadden</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 25 - 1856</u>		
7. AGE	YEARS <u>83</u>	MONTHS <u>7</u> DAYS <u>29</u>
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>House work</u>	
	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) Sept 24 1939

22. I HEREBY CERTIFY, That I attended deceased from April 1939, to Sept 24 1939
 I last saw her alive on Sept 21 1939. Death is said to have occurred on the date stated above, at 8:30 m.
 The principal cause of death and related causes of importance were as follows:
Cardiac Failure
 Date of onset 9/24

Other contributory causes of importance:
Cardiac, Hepatic, Kidney disease

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 _____
 (Signed) W.D. Collingham D.O., M. D.
34 (Address) Minerva, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER

13. NAME Simon Galay

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

MOTHER

15. MAIDEN NAME Mary Baran

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Charley Buckley
Minerva Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Minerva DATE Sept 25 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. F. Delaney
Minerva Mo.

20. FILED Oct 2 1939 G.W. Wingham
Local Registrar.

Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

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.

V. S. NO. 2.

90M-1-12-38

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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.

RECEIVED
District Health Officer No. 5,

District File Number 1038260

Date Filed 10 23 9

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.