

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
STANDARD CERTIFICATE OF DEATH

Registration District No. _____

Primary Registration District No. 6 D 119

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon 2
 (b) City or town Funeral Eminence
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 XXXX
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution XXX
 (Specify whether _____)
 In this community about a month
 years, months or days

3. (a) PRINT FULL NAME 253 Mrs. Anna Francis McEntire

3. (b) If veteran, name war XXX 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Andrew J. McEntire 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased August 20 1866
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>1</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace St. Francis Co. Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business XX

12. Name David Bunch

13. Birthplace ----- Ky 9
 (City, town, or county) (State or foreign country)

14. Maiden name Francis Davis

15. Birthplace -----
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clarence M. McEntire

(b) Address Salem Mo

17. (a) burial (b) Date thereof 10/1/39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stonehill, Mo

18. (a) Signature of funeral director Carl Kasper

(b) Address Salem Mo

19. (a) 10-1-39 (b) Frank Lido MW
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent
 (c) City or town Funeral
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location) XXX
 (e) If foreign born, how long in U. S. A.? XXXXXX years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
 year 1939 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 15
1939, Sept 30, 1939
 that I last saw her alive on Sept 28, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 1/2 hr

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. T. Budas (M. D. or other) _____

Address Funeral Home Date signed 10-1-39

RECEIVED
District Health Officer No. 5,
District File Number 1039 323
Date Filed 10/13/39

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 Carl Schmeier

Licensed Embalmer No.....

P. O. Address Salvador MS

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.