

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

38833

Do not use this space.

DEC 13 1939

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
 (b) Township _____ Primary Registration District No. 3001 Registered No. 286
 (c) City Kirksville, Mo. (d) Street No. Wm. Smith Hosp. & Clinic 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 Rebecca Harold

(a) Residence, No. _____ St. Des Moines, Iowa
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF George Harold (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78? approximate only.

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. None
 10. Date deceased last worked at this occupation (month and year) to date
 11. Total time (years) spent in this occupation 50 yrs.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know / North Carolina

FATHER 13. NAME Sam Brown

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know / North Carolina

MOTHER 15. MAIDEN NAME Unknown

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT (ADDRESS) Daughter / Missus Hester / Des Moines, Ia.

18. BURIAL, CREMATION, OR REMOVAL PLACE Burial DATE 11-27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Grace Bankhead / Burial Home

20. FILED Nov. 24 1939 Spencer R. Freeman / Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from November 23, 1939, to November 24, 1939
 I last saw her alive on November 23, 1939 Death is said to have occurred on the date stated above, at 3:05 A.M.
 The principal cause of death and related causes of importance were as follows:

Crushed chest
Fractured rt. leg above & below knee

Date of onset 11-23-39

Other contributory causes of importance:

Shock + senility

Name of operation None 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? Accident Date of injury 11-23, 1939
 Where did injury occur? 2 mi. North Councilsville, Mo.
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. Public Highway
 Manner of injury Automobile accident
 Nature of injury Crushed chest + shock

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____ (Signed) George E. Horn, M. D.

(Address) Ficksville, Missouri

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.

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RECEIVED

District Health Officer No. 10

District File Number 12-39-2178

Date Filed DEC 11 1939

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.

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Do not use this space.

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
 (b) Township _____ Primary Registration District No. 3001 Registered No. 286
 (c) City Hicksville (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 Rebecca Harold

(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 Col 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.
approx 88

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) _____

13. NAME

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

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 1-9 Spencer L. Freeman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 24 1939

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:

crushed chest
fractured rt leg below knee
free
 Other contributory causes of importance:
shoes and dignity
noe callusion - lost
control of car in avoiding callusion

Date of onset _____

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) Geo. E. Grimm, M. D.

(Address) Hicksville

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED ~~AND~~ SUBSCRIBED BY LAW.

SUPPLEMENTARY

