

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.

Registration District No. 404

Primary Registration District No. 5558

Registrar's No. 49

1. PLACE OF DEATH: Jackson

(a) County Jackson

(b) City or town Rural - Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Hickman Mills, Mo. RFD #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County Washington

(c) City or town Hickman Mills, Mo. RFD #1
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Mrs. Katie Theobald

3. (b) If veteran, name war _____

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5th
year 1939 hour 11:15 AM minute _____ M.

21. I hereby certify that I attended the deceased from 11-5 3am
1939 to 11-5 10:30, 1939.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Henry J. Theobald

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 29 1892
(Month) (Day) (Year)

that I last saw her alive on 11-5, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: Years Months Days If less than one day

47	2	6	hr. _____ min.
----	---	---	----------------

Due to Hemorrhage in throat causing asphyxiation

Due to Septic - Angina

Due to _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) 115

11. Industry or business _____

MOTHER FATHER {

12. Name George Linder

13. Birthplace Don't Know

14. Maiden name Elizabeth

15. Birthplace Don't Know

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Henry J. Theobald

(b) Address Hickman Mills, Mo. RFD #1

17. (a) Burial (b) Date thereof Nov. 8 - 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellona Mo

18. (a) Signature of funeral director R. V. Lindsey & Sons

(b) Address 3811 Broadway

19. (a) 12-7-39 (b) R. V. Lindsey & Sons
(Date received local registrar) (Registrar's Signature)

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 John R. Stivers
Address 212 Withman Date signed 11/6

MAR 29 1943

Dr. John Stivers
212 Withman Bldg.
319 Grand

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, ~~as by~~

Joseph S. Miller, Registered Apprentice No. 164
working under my personal supervision.

Signed Roscoe Wheeler

Licensed Embalmer No. 3738

P. O. Address J.C. 14

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.