

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 43977  
Registrar's No. 96

Registration District No. 538 Primary Registration District No. 6230

1. PLACE OF DEATH:  
(a) County Madison  
(b) City or town Rural (mine la motte)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution ✓  
(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

3. (a) PRINT FULL NAME Died unnamed 235  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 6 1939  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 2 hr. 30 min.

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

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Chester Weston  
13. Birthplace Womack Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Dora Virginia Reeves  
15. Birthplace Marquand Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. C. Hunter Weston  
(b) Address Mine la Motte, Mo.

17. (a) Burial (b) Date thereof 12/7/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mine la Motte Cemetery  
18. (a) Signature of funeral director none  
(b) Address \_\_\_\_\_

19. (a) Dec 7 - 1939 (b) B. G. Blount  
(Date received local registry) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Madison  
(c) City or town Rural (mine la motte)  
(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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day sixth  
year 1939 hour 8:00 minute \_\_\_\_\_ A. M.  
21. I hereby certify that I attended the deceased from Dec 6 1939 to Dec 6 1939  
that I last saw her alive on Dec 6 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death congenital weakness  
Due to Premature birth, 6 1/2 mo

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 14 15

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
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) (a) Means of injury \_\_\_\_\_

23. Signature E. W. Delaney (M. D. or other) D.O.  
Address Fredericktown Mo Date signed 12/6/39

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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.

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.**