

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.

 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

 MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

 State File No. 44788
 Registrar's No. 209

 Registration District No. 796

 Primary Registration District No. 6039

1. PLACE OF DEATH:

(a) County Saline
 (b) City or town Rural - Marshall
 (If outside city or town limits, write "RURAL" and name of township)
Saline County Home 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community 1 year
 years, months or days) 5 1/2

3. (a) PRINT FULL NAME

Lela M. Cameron

 3. (b) If veteran, name war ✓

 3. (c) Social Security No. ✓

 4. Sex Female

 5. Color or race White

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

 6. (b) Name of husband or wife W. G. Cameron

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

 7. Birth date of deceased Feb 6 - 1867
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>10</u>	<u>16</u>	hr. min.

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

 10. Usual occupation Home Keeper

11. Industry or business _____

 MOTHER FATHER { 12. Name James D. Elser

 13. Birthplace Pa
 (City, town, or county) (State or foreign country)

 14. Maiden name Elizabeth Elser

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

 16. (a) Informant's own signature J. J. Cameron

 (b) Address 1010 E 27th N.E. Mo.

 17. (a) Burial (b) Date thereof Dec 28 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

 (c) Place: burial or cremation Trinity Park Cem

 18. (a) Signature of funeral director Campbell-Hess

 (b) Address Marshall Mo

 19. (a) 12-23-39 (b) Mary Kent
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Saline
 (c) City or town Rural - Marshall
 (If outside city or town limits, write "RURAL")
 (d) Street No. Saline Co. Home
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? ✓ years.

MEDICAL CERTIFICATION

 20. DATE OF DEATH: Month Dec day 22
 year 1939 hour 10 minute 0 M.

 21. I hereby certify that I attended the deceased from Last 6 to 8 months ago to _____, 19____
 that I last saw her alive on Dec 11, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cerebral hemorrhage
hypertension
 Due to _____

hypertension
 Due to _____

 Other conditions gout
 (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. G. Elser (M. D. or other) _____

 Address Marshall Date signed 12-23

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11/2/40

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.....

R. W. Campbell, Registered Apprentice No.....
working under my personal supervision.

Signed R. W. Campbell
Licensed Embalmer No. 3469
P. O. Address Marshall, Mo.

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.