

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

JAN 10 1940

Registration District No. 849

Primary Registration District No. 6115

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Rural
(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 years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. South of Green City, Mo.
(If rural, give location)

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

3. (a) PRINT FULL NAME Amanda Jane Riddle 340

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

MEDICAL CERTIFICATION 30th

20. DATE OF DEATH: Month Dec day 29th year 1939 hour 4:00 minute _____ P. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Preston Riddle 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 21 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 25, 1939, to Dec. 29, 1939;
that I last saw her alive on Dec. 29, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia 4 days
Duration _____

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

71	9	8	_____ hr. _____ min.
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Due to CATABRICAL Jaundice

Due to _____

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

10. Usual occupation Housewife

11. Industry or business _____

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

Major findings: _____
Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name William Straley

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

14. Maiden name Mary Jane Butt Penn.
(City, town, or county) (State or foreign country)

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Mrs J. S. Spake
(b) Address Milan Mo

17. (a) Burial (b) Date thereof Jan 1, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview

18. (a) Signature of funeral director Blumen E. Kent
(b) Address Green City, Mo.

19. (a) Jan 1. 40 (b) Louisa Tubers
(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 3

23. Signature J. E. Johnson (M.D. or other) 0
Address Green City Mo. Date signed 1-1-40

RECEIVED

District Health Officer. No. 10

District File Number 1-40-9

Date Filed JAN 3 1940

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 Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Green City 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.