

STANDARD CERTIFICATE OF DEATH

State File No.

3932

Registration District No.

70

Primary Registration District No.

447

Registrar's No.

J

1. PLACE OF DEATH:

- (a) County Saline
- (b) City or town Slater
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:
X
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution A
(Specify whether)
- In this community Ten Years
years, months or days

3. (a) PRINT FULL NAME Elsie Forest Quinley. 54
3. (b) If veteran, X name war
3. (c) Social Security No. X

4. Sex Male
5. Color of race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs Pearl Hulse Quinley
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased April-27-1880
(Month) (Day) (Year)

- | 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>59</u> | <u>8</u> | <u>24</u> | hr. min. |

9. Birthplace Boonshoro, Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Telephone Employee

11. Industry or business

12. Name Don't Know
13. Birthplace Don't Know
(City, town, or county) (State or foreign country)
14. Maiden name Don't Know
15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Pearl Hulse Quinley
- (b) Address Slater Mo

17. (a) XXXXXX (Burial, cremation, or removal)
- (b) Date thereof 23-11-49
(Month) (Day) (Year)
- (c) Place: burial or cremation Ridge Park, Marshall

18. (a) Signature of funeral director Loose
- (b) Address Slater Mo
19. (a) 1-3-50 (Date received local registers)
- (b) W. M. Smith (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Saline
- (c) City or town Slater
(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.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 21
year 1940 hour 7.20 AM. minute _____ M.

21. I hereby certify that I attended the deceased from June 1938 to Jan 21 1940
that I last saw him alive on Jan 19 1940
and that death occurred on the date and hour stated above.

- Immediate cause of death Heart
Chr. Myocarditis
Chr. Endocarditis
Due to Rheumatic Disease
Syphilis

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

- Major findings:
Of operations _____

Of autopsy None

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?
no
- While at work _____ (Specify type of place)
- (e) Means of injury _____

23. Signature P. A. M. Surney (M. D. certificate)
- Address Slater, Mo Date signed 1/27/50

54

MAY 12 1958

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4/2/40

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.....

working under my personal supervision.

Registered Apprentice No.

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.

[Handwritten signature: E. Jones]
[Handwritten number: 43]
[Handwritten text: State, Ill.]

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 3932
Registrar's No. 3

Registration District No. 799

Primary Registration District No. 4479

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

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Slater
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Elsie Forest Quinley

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>8</u>	<u>24</u>	hr _____ min _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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.

20. DATE OF DEATH: Month Jan day 21
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Chr. sup. Carditis
Chr. Endocarditis
Due to radgett Disease
Syphilis of bone

Other conditions: _____ (Include pregnancy within 3 months of death) 34

Major findings:
Of operations _____
Of autopsy _____

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 C. A. Mc Burney (M. D. or other)
Address Slater mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

