

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. 71

Primary Registration District No. 5110A

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Boone
 (b) City or town Rural
 (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 _____
 In this community Life
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 7 mile South East of Ashland Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15
 year 1940 hour 11 minute 30 P.M.
 21. I hereby certify that I attended the deceased from Jan 1
1938, to Feb 15, 1940
 that I last saw her alive on Jan 1, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of face
 Duration 2 yrs

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

Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically

3. (a) PRINT FULL NAME Lorah E. Zumalt
 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 Married
 6. (b) Name of husband or wife Jama Zumalt
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec 20 1860
 (Month) (Day) (Year)

8. AGE: Years 79 Months 1 Days 25
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____
 12. Name William T. Brown
 13. Birthplace Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary
 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Brody Zumalt
 (b) Address Ashland Mo
 17. (a) Burial (b) Date thereof Feb 17-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt Zion

18. (a) Signature of funeral director Robt T Burnett
 (b) Address Ashland Mo 73
 19. (a) MAR 5, 1940 (b) Frances Nichols
 (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 H. B. Fryer (M. D. or other) 1
 Address Ashland Mo Date signed 2-27-40

52

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 *Wm C. Burnett*

Licensed Embalmer No. *3564*

P. O. Address *Asheville 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **5908**

Registration District No. **71**

Primary Registration District No. **5110c**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County **Boone**
 (b) City or town **Cedar Gap**
 (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 _____

3. (a) PRINT FULL NAME **Sarah E Zumalt**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 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 **79** Months **1** Days **25** If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Feb** day **15** year _____ 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 **Carcinoma of face**
Left side of face, cut fore part
 Due to _____
 Due to _____

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

Major findings: **SA 7. M. I. 2.**
 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 **H. C. Ryan** (M. D. or other)

Address **Ashtland, Mo** Date signed _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

