

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

7516
Do not use this space.

1. PLACE OF DEATH
 (a) County New Madrid Registration District No. 605
 (b) Township Portage Primary Registration District No. 4359
 (c) City Jallapassia (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Martha Anne Eakens
 (a) Residence, No. Jallapassia, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED (a) WIFE OF <u>W. A. Eakens, 1867</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 25 - 1910</u>				
7. AGE	YEARS <u>72</u>	MONTHS <u>1</u>	DAYS <u>16</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>at home</u>			
	10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____			
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>			
	13. NAME <u>unknown (Dillard)</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>			
MOTHER	15. MAIDEN NAME <u>unknown</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>			
17. INFORMANT <u>W. A. Eakens</u> (ADDRESS) <u>Jallapassia, Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Stanged Cem</u> DATE <u>Feb 13 1940</u>				
19. FUNERAL DIRECTOR (NAME) <u>J. C. Knight Ltd.</u> (ADDRESS) <u>Establishment, Parma, Mo.</u>				
20. FILED <u>2/12 1940</u> <u>Dr. Clewley</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>Feb 12 1940</u>
22. I HEREBY CERTIFY, That I attended deceased from <u>Feb 11 1940</u> to <u>Feb 12 1940</u> . I last saw her alive on <u>Feb 12 1940</u> . Death is said to have occurred on the date stated above, at <u>A. m.</u> The principal cause of death and related causes of importance were as follows: <u>Broncho-Pneumonia</u> Date of onset <u>15K</u>
Other contributory causes of importance: <u>Influenza</u>
Name of operation _____ Date of _____ What test confirmed diagnosis? <u>Clinical</u> Was there an autopsy? <u>no</u>
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____ Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____ Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? <u>no</u> If so, specify _____ (Signed) <u>Edward Ford</u> / M. D. (Address) <u>Parma, Mo.</u>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM 1-12-38 I X14023

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.

STATEMENT OF THE DISTRICT HEALTH OFFICER
DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

RECEIVED

District Health Officer

District File Number 34-0

Date Filed 3/14/47

RECEIVED
DISTRICT HEALTH OFFICER
DEPARTMENT OF HEALTH
DISTRICT OF COLUMBIA

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **75-16**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **605**

Primary Registration District No. **4539**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Cons 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
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Martha Ann Eakens**

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 **Dec 25-1 1949**
(Month) (Day) (Year)

8. AGE: Years **72** Months **1** Days **16** If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **4-12-40** (b) **Dr. Ernest Kuster**
(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 **Feb** day **2**
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 _____

Due to _____
Due to _____

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

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) _____
(c) Means of injury _____

23. Signature **Edward Ford** (M. D. or other) _____
Address **Parma Mo** Date signed _____

SUPPLEMENTARY

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

