

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10012**

FILED APR 18 1940

Registration District No. **2**

Primary Registration District No. **4004**

Registrar's No. **77**

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Nowinger
(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) 2
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 36 years years, months or days

3. (a) PRINT FULL NAME SECONDIRIA GIMA
8. (b) If veteran, name war _____ **8. (c) Social Security** No. _____

4. Sex Female **5. Color or race** W **6. (a) Single, widowed, married,** divorced WIDOWER
6. (b) Name of husband or wife PETEY GIMA **6. (c) Age of husband or wife if** alive _____ years
7. Birth date of deceased May 13 1867 (Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Italy (City, town, or county) (State or foreign country) 7

10. Usual occupation HOUSE WIFE

11. Industry or business _____

MOTHER FATHER
12. Name Thomas Costa 7
13. Birthplace Italy (City, town, or county) (State or foreign country)
14. Maiden name Catherine Vica 7
15. Birthplace Italy (City, town, or county) (State or foreign country)

16. (a) Informant Catherine Jackson
(b) Address Youngs Town, Mo

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 4-1-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Nowinger Cem.

18. (a) Signature of funeral director Walter D. ...
(b) Address Keokuk, Mo.

19. (a) 4-9-40 (Data received local registrar) **(b) Spencer A. Meenan** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Nowinger (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.? Italy years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 30 year 1940 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from March 15 1940 to March 30 1940
that I last saw her alive on March 30 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Influenza **Duration** 2 weeks

Due to Chronic Valvular Heart Disease

Other conditions Chronic Valvular Heart Disease (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? ✓

3. While at work? (Specify type of place) (a) Means of injury _____
23. Signature W. H. Garrison (M. D. or other)
Address Nowinger 765 **Date signed** 4-1-40

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

RECEIVED

District Health Officer No. 10

District File Number 4-40-848

Date Filed APR 16 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

J. E. Riley

Licensed Embalmer No. 3908

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 10012

Registration District No. 2

Primary Registration District No. 4004

Registrar's No. 77

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

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Nowinger
(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 Secondina Cima

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 w

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

7. Birth date of deceased May 13 1869
(Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 17 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) May 1-40 (b) Spencer L. Dreame
(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.

3. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 30
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) _____ (e) Means of injury _____

23. Signature H. G. Harrison (M. D. or other) _____

Address Nowinger _____ Date May 1-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-10012 1940