

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15390

State File No. _____

Registration District No. 301

Primary Registration District No. 3666

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Rural Locust Creek, Mo
(c) Name of hospital or institution: Linn Co Infirmary
(d) Length of stay: In hospital or institution 25 years
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn
(c) City or town Rural
(d) Street No. _____
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Anna Ferris 620

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased May 7 1842
(Month) (Day) (Year)

8. AGE: Years 98 Months - Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name A. M. Glenn 13. Birthplace Ny

14. Maiden name A. Pether 15. Birthplace Mo

16. (a) Informant's own signature Rory Glenn (b) Address Brookfield Mo

17. (a) Burial (b) Date thereof May 10 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sinners Mt Hill General Chapel

18. (a) Signature of funeral director _____ (b) Address Brookfield Mo 563
19. (a) May 10 1940 (b) Maud T. Webb
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
year 1940 hour 11 minute 45 P. M.

21. I hereby certify that I attended the deceased from Feb 16
1936, to May 3, 1940;
that I last saw her alive on May 3, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Senility. Duration _____

Due to _____

Due to _____
Other conditions Myocardial Degeneration 2 yr
(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? _____
(Specify type of place) (e) Means of injury _____

While at work? _____
28. Signature Rory Glenn (M. D. or other) MD
Address Brookfield Date signed 5/19/40

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.

RECEIVED

District Health Office No. 11;

District File Number 540-740

Date Filed MAY 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.....

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.