

JUL 15 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21321  
State File No. \_\_\_\_\_  
Registrar's No. 188

Registration District No. 89

Primary Registration District No. 302-85157

1. PLACE OF DEATH:  
(a) County: Butts Mo. Hill  
(b) City or town: Quibus Rural  
(c) Name of hospital or institution: Home  
(d) Length of stay: In hospital or institution: 1 year  
In this community: 1 year

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Mo (b) County: Butts  
(c) City or town: Quibus - Rural  
(d) Street No.: 12 m. E. Zulim  
(e) If foreign born, how long in U. S. A.:

3. (a) PRINT FULL NAME: Katie Wahlbreght  
(b) If veteran, name war: no  
(c) Social Security No.:

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 21  
year 1940 hour 10 minute 45 P.M.

4. Sex: F 5. Color or race: W 6. (a) Single, widowed, married, divorced: Married  
6. (b) Name of husband or wife: Writing Wahlbreght 6. (c) Age of husband or wife if alive: 66 years  
7. Birth date of deceased: Don't know

21. I hereby certify that I attended the deceased from 4/21 - 1940 to June 21, 1940; that I last saw her alive on June 21, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Infarctus Duration: 10 hrs

8. AGE: Years About 58 Months Days If less than one day hr. min.

Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_

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

10. Usual occupation: Home wife

Other conditions: None (include pregnancy within 3 months of death)

11. Industry or business: \_\_\_\_\_

Major findings: Of operations: no

12. Name: Don't know

Of autopsy: no

13. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name: Don't know (City, town, or county) (State or foreign country)

15. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Katie Wahlbreght (b) Address: Quibus

17. (a) (b) Date thereof: 6/23/40 (Month) (Day) (Year)

18. (a) Signature of funeral director: James H. ... (b) Address: ...

19. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify): no  
(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?  
(e) Means of injury: \_\_\_\_\_  
23. Signature: L. H. Coon (M. D. or other) 1  
Address: Quibus Mo Date signed: 6/22/40

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

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

REV. 5-17-39  
FORM 1 X1931

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.

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36

**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. 21321  
Registrar's No. 188

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 89

Primary Registration District No. 5131

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

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Cash Hill T.P.  
(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

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. (a) PRINT FULL NAME Katie Hoalbright

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

20. DATE OF DEATH: Month June day 21  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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 \_\_\_\_\_ year

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

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 acute Gastritis Duration \_\_\_\_\_

8. AGE: aft 58 Years Months Days If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Gastritis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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 \_\_\_\_\_

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? \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

23. Signature Seath Cook (M. D. or other) \_\_\_\_\_  
Address Julin mo Date signed \_\_\_\_\_

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

