

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. 689

Primary Registration District No. 3033

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Pike  
 (b) City or town Louissiana, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Pike County Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15 hours  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Nancy A Wright 62-3  
 (b) If veteran, name war \_\_\_\_\_  
 (c) Social Security No. none

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced married  
 (b) Name of husband or wife Barnie Bush Knight  
 (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased March 13 1901  
(Month) (Day) (Year)

8. AGE: Years 39 Months 3 Days 9  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER  
 12. Name Henry Painter  
 13. Birthplace Pike Co. Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Margaret Knight  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Nancy Wright

(b) Address Bowling Green, Mo.

17. (a) Burial (b) Date thereof 6-24-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowling Green Cem

18. (a) Signature of funeral director Grace Bantread

(b) Address Bowling Green Mo

19. (a) 6/23/40 (b) J. G. H. W.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Pike  
 (c) City or town Bowling Green  
(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 June day 22  
 year 1940 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from 6/12/40  
 \_\_\_\_\_, 19\_\_\_\_, to 6/22, 19\_\_\_\_  
 that I last saw her alive on 6/22, 19\_\_\_\_  
 and that death occurred on the date and hour stated above

Immediate cause of death Acute Encephalitis Duration \_\_\_\_\_

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

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

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

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

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

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? \_\_\_\_\_

620  
(Specify type of place) While at work? (e) Means of injury \_\_\_\_\_

23. Signature Engelbert Barrymore (M. D. or other) 1

Address Bowling Green, Mo Date signed 6/24/40

75  
RECEIVED

District Health Officer No. 10

District File Number 2-40-1355

Date Filed JUL 8 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 Grace Banthead

Licensed Embalmer No. 2204

P. O. Address Bowling Green, 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. 225-41

Registration District No. 689

Primary Registration District No. 3033

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Rifle  
(b) City or town Louisiana, Mo.  
(If outside city or town limits, write "RURAL" and name of town)  
(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 \_\_\_\_\_ (Specify whether  
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 Nancy A. Wright

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 in

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 \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

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

MOTHER { 12. Name \_\_\_\_\_  
FATHER { 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 \_\_\_\_\_ (Month) (Day) (Year)

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

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

(b) Address \_\_\_\_\_

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 22 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 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death acute encephalitis

Due to (non epidemic)

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

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

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

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

Duration

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? \_\_\_\_\_

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

23. Signature Eugene Barrymore (M. D. or other) \_\_\_\_\_

Address Bowling Green Date signed in

SUPPLEMENTAL

