

1942
99

RECEIVED

District Health Officer No: 10

District File Number 8-40-1646

Date Filed AUG 15 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 Kirkville, 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. **24478**

Registration District No. **1**

Primary Registration District No. **200**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Walnut 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.....
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

Martha Ann Meek

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 **wid**
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 **82** Months **2** Days **6** 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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) **Sept 2/40** (b) **Spencer L. Freeman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **21**
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..... **Pneumonia** Duration

Due to.....

Due to.....

Other conditions..... **Fractured femur**
(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) **Accident**

(b) Date of occurrence..... **Sept 2/40**

(c) Where did injury occur? **Yarrow, Mo death**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In her home

While at work?..... (Specify type of place) (e) Means of injury **fall out bed**

23. Signature **C. L. Martin** (M. D. or other)

Address **Warrensburg** Date signed **mo**

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

SUPPLEMENTAL

