

AUG 10 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

24765
Do not use this space.

1. PLACE OF DEATH

(a) County Caldwell Registration District No. 95

(b) Township W. 1 Primary Registration District No. 3141

(c) City Cowgill (d) Street No. _____ St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Fannie Schuster

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. L. Schuster

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 17, 1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

65	8	5	
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OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Duties

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Tatesville, Mo.

FATHER

13. NAME W. H. Yoakum

14. BIRTHPLACE (CITY OR TOWN) Nashville, Tenn.

MOTHER

15. MAIDEN NAME Nancy Jane Hendrix

16. BIRTHPLACE (CITY OR TOWN) Richmond, Mo.

17. INFORMANT J. L. Schuster
(ADDRESS) Cowgill, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Cowgill, Mo. DATE July 24, 1940

19. FUNERAL DIRECTOR (NAME) E. Thurman
(ADDRESS) Richmond, Mo.

20. FILED July 29, 1940 Mr. M. D. Forbes
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 22, 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw her alive on Not at all, 19____. Death is said to have occurred on the date stated above, at 12:30 P.M.

The principal cause of death and related causes of importance were as follows:

Mitral Regurgitation

Date of onset 2

Other contributory causes of importance: 92 W

Name of operation _____ Date of _____

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) L. M. Daley (Coroner) M. D.

(Address) Hannibal, Mo

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 Officer No. 11,

District File Number 640-1039

Date Filed AUG 6 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, #####

....., Registered Apprentice No.....
working under my personal supervision.

Signed *E. Thurman*

Licensed Embalmer No. 2073

P. O. Address Richmond, 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

State File No. **24765**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **95**

Primary Registration District No. **3141**

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County **Caldwell**
(b) City or town **Lincoln**
(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 **Fannie Schuster**

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 **m**

6. (b) Name of husband or wife **J. L. Schuster** 6. (c) Age of husband, or wife, if alive **72** years

7. Birth date of deceased **November 17 1874**
(Month) (Day) (Year)

8. AGE: Years **65** Months **8** Days **5**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **house duties**

11. Industry or business _____

MOTHER FATHER
12. Name **W. F. Yeast**
13. Birthplace **Nashville, Tenn.**
(City, town, or county) (State or foreign country)
14. Maiden name **Nancy Jane Hendrix**
15. Birthplace **Richmond, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **J. L. Schuster**
(b) Address **Cougill, Mo.**

17. (a) _____ (b) Date thereof **7 24 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Cougill Cemetery**

18. (a) Signature of funeral director **E. Thurman**
(b) Address **Richmond, Missouri**

19. (a) **7/29/1940** (b) **Mrs. M. D. Forbes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Caldwell**
(c) City or town **Cougill**
(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.

DEATH CERTIFICATION

20. DATE OF DEATH: Month **July** day **22**
year **1940** hour **12.30** minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw her alive on **not at all** _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **mitral regurgitation**

Due to _____
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) (c) Means of injury _____

23. Signature **L. M. Naley**
Address **Hamilton** _____ signed

