

Registration District No. 783

Primary Registration District No. 6029

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Genevieve, Missouri
 (b) City or town St. Genevieve
 (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 Missouri (b) County St. Genevieve
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1 1/2 miles East of Coffman, Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME MARY-AGATHA-VALLE
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 25th year 1940 hour 15 minute 20 A. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Anthony Valle 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 23rd 1861
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 1, 1940 to July 28, 1940
 that I last saw her alive on July 28, 1940
 and that death occurred on the date and hour stated above.

8. AGE: Years 79 Months 6 Days 5 If less than one day _____ hr. _____ min.

Immediate cause of death Broncho Pneumonia
 Due to Uremia
Hemiplegia

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

Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

10. Usual occupation Housewife

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? 704
 (Specify type of place) _____
 While at work? _____ (a) Means of injury _____

11. Industry or business _____
 12. Name Frank Vogt
 13. Birthplace St. Genevieve, Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Hester
 15. Birthplace St. Genevieve, Missouri
 (City, town, or county) (State or foreign country)

23. Signature P. Applebury (M. D. or other) _____
 Address Farmington Date signed 7/28/40

16. (a) Informant's own signature Emily Valle
 (b) Address Coffman, Missouri
 17. (a) Coffman (b) Date thereof July 30th 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Coffman, Missouri

18. (a) Signature of funeral director Walter Stanton
 (b) Address St. Genevieve, Missouri
 19. (a) July 30, 1940 (b) Mrs. A. H. Boyd
 (If received local registrar) (Registrar's signature)

PHYSICIAN
 Underline the cause to which death should be charged statistically

USE UNWADING 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.

1972

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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 *Warrin J. Stanton*
Licensed Embalmer No. *3328*
P. O. Address *St. James*

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.

Registration District No. 783

Primary Registration District No. 6029

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Genevieve
 (b) City or town Saline Twp
(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)
 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.

(a) PRINT FULL NAME

Mary Agatha Valle

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

DECEASED CERTIFICATION

20. DATE OF DEATH: Month July day 28
 year _____ 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.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
 (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

Immediate cause of death Bronchitis

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

Duration _____

8. AGE: Years 79 Months 6 Days 5 If less than one day _____ hr. _____ min.

Due uremia

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

Due Heniplegia Cerebral Hemiplegia

10. Usual occupation _____

Other conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

11. Industry or business _____

PHYSICIAN _____

12. Name _____

Major findings: _____

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

Of operations _____

14. Maiden name _____

Of autopsy _____

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

Underline the cause to which death should be charged statistically.

16. (a) Informant _____ (b) Address _____

22. If death was due to external causes, fill in the following:

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

(a) Accident, suicide, or homicide (specify) _____

(c) Place: burial or cremation _____

(b) Date of occurrence _____

18. (a) Signature of funeral director _____ (b) Address _____

(c) Where did injury occur? _____
(City or town) (County) (State)

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

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

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed 8/6/20

SUPPLEMENTAL

MOTHER FATHER

