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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26487

Registration District No. _____ Primary Registration District No. 849-4515 Registrar's No. 4515

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

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Green City
(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 years, months or days). In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Sullivan
(c) City or town Green City
(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 Ida May Draper 616
3. (b) If veteran, name war 2
3. (c) Social Security No. V

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Samuel Draper
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Octover (Month) 8 (Day) 1867 (Year)

8. AGE: Years 72 Months 9 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Near Memphis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Hezekiah Cain
13. Birthplace Don't know (City, town, or county) Don't know (State or foreign country)
MOTHER 14. Maiden name Don't know
15. Birthplace Don't know (City, town, or county) Don't know (State or foreign country)
16. (a) Informant Chas. Draper
(b) Address Hugo, Colo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet
18. (a) Signature of funeral director Glenn E. Kent
(b) Address Green City Mo.
19. (a) Aug 1-1940 (Date received local registrar) (b) Virginia Gibson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1940 hour 5:00 minute P M.
21. I hereby certify that I attended the deceased from July 1, 1940, to July 29, 1940, that I last saw her alive on July 27, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Cardio Vascular Renal Disease — 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 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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature L. E. Schure (M. D. or other) 3
Address Green City Mo. Date signed 8-1-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-40-1532
Date Filed AUG 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. ~~1767~~
working under my personal supervision.

Signed Glenn E Kent

Licensed Embalmer No. 1769

P. O. Address Green City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.