

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. **690** Primary Registration District No. **5918** Registrar's No. **7**

1. PLACE OF DEATH:
 (a) County **Pike**
 (b) City or town **Rural, Scotland**
 (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 **2**
 (Specify whether
 In this community
 years, months or days)
3. (a) PRINT FULL NAME **Floy Olive Worrell**
3. (b) If veteran, name war **7**
3. (c) Social Security No. **640**
4. Sex **Female** **5. Color or race** **W**
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if
7. Birth date of deceased **July 1902** **1902**
 (Month) (Day) (Year)

8. AGE: Years **18** Months **22** Days **22** If less than one day hr. min.
9. Birthplace **Pike Co mo** (City, town or county) (State or foreign country)
10. Usual occupation **at home**

11. Industry or business
MOTHER FATHER
12. Name **Harry Worrell**
13. Birthplace **Pike Co mo** (City, town or county) (State or foreign country)
14. Maiden name **Anna May Lee**
15. Birthplace **Moulton Co mo** (City, town or county) (State or foreign country)

16. (a) Informant's own signature **Harry Worrell**
(b) Address **Near Scotland Mo**
17. (a) [Signature] **(b) Date thereof** **8-12-40**
 (Burial, cremation, etc.) (Month) (Day) (Year)
(c) Place: burial or cremation **Middleton Mo**
18. (a) Signature of funeral director **James & Wells**
(b) Address **Middleton Mo**
19. (a) Aug 11-1940 Mrs Lys Moore
 (Date recd at local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Pike**
 (c) City or town **Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Near New Scotland mo**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug 11** day _____ year _____ hour _____ minute **5:30 A.M.**
21. I hereby certify that I attended the deceased from **Aug 10 1940**
 _____, 19____, to **Aug 11 1940**
 that I last saw her alive on **Aug 9 1940**, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of ovaries, lungs and cerebrum
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death)
PHYSICIAN
 Major findings: Of operations _____
 Of autopsy _____
 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 **A. Finch** (M. D. or other) _____
 Address **Middleton Mo** Date signed **Aug 11 1940**

47

8192

07.

RECEIVED

District Health Officer No. 10

District File Number 9-40-1683

Date Filed SEP 5 1940

Rybaie Inome.

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

W.B. Kelly

Licensed Embalmer No.

P. O. Address

Kellyville, 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.

SEP-11 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29377**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **690**

Primary Registration District No. **2918**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Beaver**
(b) ~~City or town~~ **Hartford T.C.**
(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

Flay Olive Starrell

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 _____
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 **18** Months **-** Days **22** 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 _____
(Burial, cremation, or removal) (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 **Aug** day **1**
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 **Carcinoma of base of larynx and cerebrium**

Due to **Carcinoma of**

Due to **Metaplasia of larynx was primary site**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____ **47**

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) (b) Means of injury _____

23. Signature **A. H. Finch** (M. D. or other) _____

Address **Middleton, Mo** Date signed **10/1/40**

SUPPLEMENTAL

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

