

SEP 25 1940

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

30032  
Do not use this space.

1. PLACE OF DEATH

(a) County Webster Registration District No. 996  
(b) Township Grant Primary Registration District No. 6199  
(c) City Grant (d) Street No. \_\_\_\_\_ Registered No. 23  
(e) Length of residence in city or town where death occurred 53 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

600 Martha Rowena Tarr  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William H. Tarr

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 29-1864

7. AGE YEARS 75 MONTHS 10 DAYS 24 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as saw mill, bank, etc. Home  
10. Date deceased last worked at this occupation (month and year) 1939 11. Total time (years) spent in this occupation life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

FATHER 13. NAME Samuel Perry Rankin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

MOTHER 15. MAIDEN NAME Alice Ayers

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

17. INFORMANT (ADDRESS) Will H. Tarr  
Marshfield, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Marshfield DATE April 24 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ess Piney  
Marshfield, Missouri

20. FILED Aug 5 1940 Elizabeth Heald  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 23 1940

22. I HEREBY CERTIFY, That I attended deceased from April 20 1940 to Apr 23 1940  
I last saw h. 21 alive on April 20 1940. Death is said to have occurred on the date stated above, at 5:30 A.M.  
The principal cause of death and related causes of importance were as follows:

Carcinoma of throat.

Other contributory causes of importance: 40

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) J. W. Buyer M. D.  
Marshfield Mo (address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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!

504-4-19-35 I X16605

RECEIVED

District Health Officer No. 6,

District File Number 940-2589

Date Filed SEP 12 1940

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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 Tex Hainey.....

Licensed Embalmer No. 3312.....

P. O. Address Marshfield, 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. **30032**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **896**

Primary Registration District No. **6199**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County **Webster**  
(b) City or town **Wentz T.P.**  
(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 **Martha Rowena Tarr**

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 **w**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

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

8. AGE: Years **75** Months **10** Days **24** 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)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) **10-22-40** (b) **L. H. Hylton** (Registrar's signature)

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Webster**

(c) City or town **Marshallfield, Mo**  
(If outside city or town limits write "RURAL")

(d) Street No. **R# 2**  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
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.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature **J. R. Bruce** (M. D. or other) \_\_\_\_\_

Address **Marshallfield** Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

