

No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31684

Registration District No. 152

Primary Registration District No. 5216

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cass
(b) City or town East Lynne
(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 10 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cass
(c) City or town East Lynne
(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

JUDITH ANN SHALE

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 S

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years
(Day) (Year)

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

8. AGE:

Years _____ Months _____ Days 10
If less than one day hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Leon Shale

13. Birthplace Clarence MO.
(City, town, or county) (State or foreign country)

14. Maiden name Bertha Albright

16. Birthplace Harrisonville MO.
(City, town, or county) (State or foreign country)

16. (a) Informant Leon Shale

(b) Address East Lynne MO

17. (a) Burial (b) Date thereof Sept 30 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarence MO

18. (a) Signature of funeral director J. O. Hartzler

(b) Address East Lynne MO

19. (a) 9-30-40 (b) Ms E. H. Stonestreet
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 29
year 1940 hour 13 minute _____ A.M.

21. I hereby certify that I attended the deceased from Sept. 19
1940 to Sept 29 1940
that I last saw her alive on Sept. 27 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital malformation of heart
Duration since birth

Due to Failure of Foramen Ovale to completely close

Other conditions _____
(Include pregnancy within 3 months of death) 157 C

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? 145

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

23. Signature Geo. C. Wilder (M. D. or other) DO

Address 1040 Pearl Date signed 9/29/40

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

Harrisonville Mo.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.