

OCT 12 1940 89
Registration District No. 28

Primary Registration District No. 5283

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Rural Clay 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)
(d) Length of stay: In hospital or institution 2
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clark
(c) City or town Rural Alexandria
(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 Martha Fox

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife J. W. Fox 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 21, 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Lewis Co. Mo
(City, town or county) (State or foreign country)

10. Usual occupation Retired Housewife

11. Industry or business _____

12. Name Wm. Baxter

13. Birthplace West Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Rosanna Woods

15. Birthplace New Madrid Co. Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ben Schneider

(b) Address Alexandria, Mo

17. (a) Burial (b) Date thereof Sept. 22, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bluff Springs Cem.

18. (a) Signature of funeral director H. P. Kirchner
(b) Address Wayland, Mo

19. (a) Sept 23 (b) D. F. A. S. Rebo
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 20th,
year 1940 hour 11:00 minute A. M.

21. I hereby certify that I attended the deceased from July 20 1940 to July 20, 1940
that I last saw her alive on July 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Dementia Praecox /
General Paralysis

Duration

6 months

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? _____

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

23. Signature D. F. A. S. Rebo (M. D. or other) Dr.
Address Alexandria Mo Date signed Oct 4

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

2315

22A

RECEIVED

District Health Officer No. 10

District File Number 10-40-1839

Date Filed OCT 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

Vernon C. Ryan

Registered Apprentice No. 264

working under my personal supervision.

Signed

H. G. Kirsch

Licensed Embalmer No. 2611

P. O. Address Wayland, N.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **31727**

Registration District No. **189**

Primary Registration District No. **2275-**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Clay 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 Joy

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 wid

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	Months	Days	If less than one day
<u>76</u>	<u>4</u>	<u>29</u>	hr _____ min _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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)

(c) Place: burial or cremation _____

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

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

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Dementia Precox
General Paralysis
Due to General Paralysis
of the Insane
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 87

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) _____ (c) Means of injury _____

23. Signature D. F. A. S. Roberts (M. D. number) _____
Address Albany, Mo. Date signed 10-17

SUPPLEMENTARY

