

1940 OCT 23

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

33401
Do not use this space.

1. PLACE OF DEATH

(a) County Washington
(b) Township Belgrade
(c) City
(e) Length of residence in city or town where death occurred yrs. mos. ds.

Registration District No. 908
Primary Registration District No. 0185

Registered No. 90

(d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nancy Thomas

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph Thomas

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9/5/1870

7. AGE YEARS 70 MONTHS 1 DAYS 5 If LESS than 1 day, hrs. or min.

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.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dent Co. MO

13. NAME Lloyd Adams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) dont know

15. MAIDEN NAME Mary Ferry

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) dont know

17. INFORMANT Henty Wood (ADDRESS) Belgrade, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE near Manufacture DATE 10-11

19. FUNERAL DIRECTOR (NAME) Norman White (ADDRESS) Wagon Mo.

20. FILED 10-11 1940 Ms Ella White Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/9 1940

22. 9/9 I HEREBY CERTIFY, That I attended deceased from 10/9 1940

I last saw her alive on 10/8 1940 Death is said to have occurred on the date stated above, at 1 P m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of stomach

Date of onset

Other contributory causes of importance:

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 _____, 1940

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? _____ no specify _____

(Signed) J. P. Heasler, M. D.
(Address) Ironside, Mo.

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.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33401**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **968**

Primary Registration District No. **6183**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Washington**
(b) City or town **Bellevue**
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Nancy Thomas

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 **m**
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 **70** Months **1** Days **5** If less than one day _____ 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **10-10-1940** (b) **Mrs Golla White**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Washington**
(c) City or town **Rural**
(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 **10** day **9**
year **1940** 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 _____

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.P. Yeagan** (M. D. or other) _____

Address **San Luis** _____ signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

