

STANDARD CERTIFICATE OF DEATH

State File No. 35098

Registration District No. 197

Primary Registration District No. 5276A

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town North Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2101 Clay
(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 5 weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
 (c) City or town Novinger
(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 Oct day 24
 year 40 hour 3 minute 15 A M.
 21. I hereby certify that I attended the deceased from Sept 1
 1940 to Oct 21, 1940
 that I last saw him alive on Oct 24, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Prostate pneumonia
 Due to hypernatremia
free of stroke!
 Due to _____
 Other conditions:
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 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?
963
(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
 Address [Address] Date signed Oct 28

3. (a) PRINT FULL NAME Lottie Mashburn Tavinne

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mike Tavinne 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased: Feb. 22 1877
(Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 1 If less than one day hr. _____ min. _____

9. Birthplace: Springfield Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Domestic

MOTHER { 12. Name John Mashburn
 18. Birthplace Springfield Mo.
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah Tindall
 15. Birthplace Springfield Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Pauline Palmer
 (b) Address N. Kansas City, Mo.

17. (a) Burial (b) Date thereof 10/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Novinger (Cemt) Mo.

18. (a) Signature of funeral director Davis Funeral Home
 (b) Address Kirksville, Missouri

19. (a) 10-25-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

17-3v
X21492

NOV 20 1940

46

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-18-40

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. ~~4076~~
working under my personal supervision.

Signed *Harold N. Hegal*
Licensed Embalmer No. *4076*
P. O. Address *Kirksville, 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. **35098**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **197**

Primary Registration District No. **2276A**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Clay**
(b) City or town **St. R. C.**
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Lettie Mashburn Tairone**

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 _____ years

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

8. AGE: Years **63** Months **8** Days **1** If less than one day _____ 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)

(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 **Oct** day **24** year **1970** 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 **Broncho pneumonia** Duration _____

Due to **Carcinoma, Lungs and intestinal tracts**

Due to **# Primary site**
Other conditions **metastases #**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **46**

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) (e) Means of injury _____

23. Signature _____ M. D. or other _____

Address _____ Date signed **10/24/70**

SUPPLEMENTAL

