

No. 2
-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35704

State File No. _____

Registration District No. 470

Primary Registration District No. 56.3.3

Registrar's No. 130

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Mount Vernon
(c) Name of hospital or institution: Missouri State Sanatorium
(d) Length of stay: In hospital or institution 519 days
In this community 519 days

3. (a) PRINT FULL NAME Janet Marie Curtis

3. (b) If veteran, name war No 3. (c) Social Security None known

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

6. (b) Name of husband or wife Martin Curtis 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased August 7th 1914

8. AGE:	Years	Months	Days	If less than one day
	<u>26</u>	<u>2</u>	<u>2</u>	hr. min.

9. Birthplace Bland Missouri

10. Usual occupation Housewife

11. Industry or business 1

12. Name Albert Moore

13. Birthplace Erie Penna.

14. Maiden name Leona Ida Decker

15. Birthplace Byron Penna

16. (a) Informant E. McMichael, Record Clerk

(b) Address Missouri State Sanatorium

17. (a) Removal (b) Date thereof 10-9-1940

(c) Place: burial or cremation Belle Mo

18. (a) Signature of funeral director Geo B. Orr

(b) Address Mount Vernon Mo

19. (a) 10/9/1940 (b) P.A. HOLMES

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maries
(c) City or town Belle
(d) Street No. _____
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9th
year 1940 hour 12:45 minute _____ P. M.

21. I hereby certify that I attended the deceased from May 8th 1939 to Oct. 9th 1940
that I last saw her alive on October 9th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____
Due to _____

Other conditions Tuberculous Emphysema, etc
Enteritis, Tuberculosis

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 _____

Where did injury occur? _____
(c) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

28. Signature [Signature] (M. D. or other) MD
Address Mount Vernon, Mo Date signed 10/9/40

Duration 2 yrs.
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.