

S. No. 11-10 7-5-17

DEPARTMENT OF COMMERCE
BUREAU OF THE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35765**

NOV 20 1940

Registration District No. **518**

Primary Registration District No. **4574**

Registrar's No.

1. PLACE OF DEATH:

(a) County McDonald

(b) City or town Anderson
(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) 2

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Elizabeth Nolan

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 Married

6. (b) Name of husband or wife John Nolan **6. (c) Age of husband or wife if** alive 70 years

7. Birth date of deceased Dec. 19 1875
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>9</u>	<u>12</u>	hr. _____ min. _____

9. Birthplace Wallis Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife 9

11. Industry or business Home 9

MOTHER FATHER

12. Name John Ragan

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Honey Bennett

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant John Nolan
(b) Address Anderson, Mo.

17. (a) Burial **(b) Date thereof** 10-2-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson

18. (a) Signature of funeral director M. H. Snow
(b) Address Anderson, Mo.

19. (a) Oct 3 1940 **(b) Mrs. Lee Harper**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald

(c) City or town Anderson
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1 year _____ hour _____ minute _____

21. I hereby certify that I attended the deceased from Sept 1-40
_____ 1940 to Sept 1 1940
that I last saw her alive on Sept 11 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Valvular Disease of Heart

Due to Myocardial Infarction

Due to Not known

Other conditions (Include pregnancy within 3 months of death) None

PHYSICIAN

Major findings: None

Of operations: _____

Of autopsy: None

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? 463

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

23. Signature J. B. Rued (M. D. or other) _____
Address Anderson, Mo. **Date signed** Sept 10

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

RECEIVED

District Health Officer No. 6,

District File Number 1040-2783.

Date Filed OCT 31 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed M. W. Snow

Licensed Embalmer No. 4034

P. O. Address Anderson, 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.

Registration District No. 518

Primary Registration District No. 4574

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County McDonnell
 (b) City or town Anderson
(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: ¹ In hospital or institution _____
(Specify whether years, months or days)

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) Citizen of foreign country _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Elizabeth Nolan
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 1
 year 1940 hour 3 o'clock minute _____ a. 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 _____

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 _____ year _____
 7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

Duration _____
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years 65 Months 9 Days 12 If less than one day _____ hr _____ min.

Major findings:
 Of operations _____
 Of autopsy _____

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

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
 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 _____
(Burial, cremation, or removal) (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)

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)
 (b) Means of injury _____

23. Signature J. B. Reed (M. D. or other) _____
 Address Anderson _____

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

MOTHER FATHER

SUPPLEMENTAL

