

## STANDARD CERTIFICATE OF DEATH

State File No.

35789

Registration District No.

588

Primary Registration District No.

5725

Registrar's No.

66

## 1. PLACE OF DEATH:

- (a) County Madison  
 (b) City or town Rural Jewett Liberty  
 (c) Name of hospital or institution:  
 (If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)In this community \_\_\_\_\_  
years, months or days3. (a) PRINT FULL NAME Ida May Firebaugh3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. 54. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Manuel H Firebaugh 6. (c) Age of husband or wife if alive 66 years7. Birth date of deceased Nov 2 1978  
(Month) (Day) (Year)8. AGE: Years 62 Months 11 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Madison Co Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Home11. Industry or business Home12. Name Bolden Watts18. Birthplace Kentucky  
(City, town, or county) (State or foreign country)14. Maiden name Susie Watts15. Birthplace Madison Co Mo  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature I. H. Firebaugh(b) Address Jewett17. (a) Burial (b) Date thereof Oct 9 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Burial Cem. Mad Co Mo18. (a) Signature of funeral director E. H. Webb(b) Address Fredericktown Mo19. (a) Oct 9 1940 (b) S. C. S. Lawler  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Madison  
 (c) City or town Rural Liberty  
 (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 7  
year 1940 hour 9 minute 40 P. M.21. I hereby certify that I attended the deceased from Sept 2-1940  
1940 to Sept 29 1940;  
that I last saw her alive on Sept 1 1940;  
and that death occurred on the date and hour stated above.Immediate cause of death Pneumonia Duration 10 days  
Bronchitis + cold Sept 1940

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_23. Signature H. G. Webb (M. D. or other) \_\_\_\_\_Address 1004-50 78 St Date signed Oct 8-40

1066

**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.....

*Was not embalmed*, Registered Apprentice No.....  
working under my personal supervision.

Signed *Ed. H. Webb*

Licensed Embalmer No. *731*

P. O. Address *Frederick Town Md*

**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. **35-789**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **038**

Primary Registration District No. **0725**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Madison**  
(b) City or town **Liberty**  
(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 **Ida May Firebaugh**

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

4. Sex **7** 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 **62** Months **1** Days **5** If less than one year, hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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. years

20. DATE OF DEATH month **Oct** day **7** year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death **Pneumonia** Duration

Due to **Bronchitis + cold**  
**Bronchial Pneumonia**

Due to  
Other conditions (Include pregnancy within 3 months of death)  
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) While at work? (e) Means of injury

23. Signature **H. V. Moore** (M. D. or other) Address **1024 - 30th** Date signed

SUPPLEMENTAL

