

Registration District No. FILED NOV 25 1940

Primary Registration District No. 6145

Registrar's No.

1. PLACE OF DEATH: Texas
 (a) County Texas
 (b) City or town Jackson
 (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 2
 (Specify whether
 In this community
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Texas
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3 miles N.E. Raymondville
 (If rural, give location)
 (e) If foreign born, how long in U.S.A? _____ years.

3. (a) PRINT FULL NAME FRANKIE AMBERN
 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 Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec. 22 1844
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 20
 year 1940 hour 5 minute 30 P.M.
 21. I hereby certify that I attended the deceased from Oct 20, 1940, to _____, 1940;
 that I last saw W alive on Oct 20, 1940,
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>95</u>	<u>9</u>	<u>20</u>	hr. _____ min. _____

Immediate cause of death apoplexy
 Due to Chronic nephritis
 Due to _____
 Other conditions (include pregnancy within 3 months of death) 171

9. Birthplace Unknown Tenn.
 (City, town, or county) (State or foreign country)
 10. Usual occupation House work 1
 11. Industry or business Home 3
 12. Name Alexander Ambern
 13. Birthplace Unknown Tenn
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 16. (a) Informant James R. Halden
 (b) Address Raymondville Mo
 17. (a) Burial (b) Date thereof 10/21/40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Boone Creek
 18. (a) Signature of funeral director Saylor D. Elliott
 (b) Address Houston Mo
 19. (a) Oct. 21-40 (b) Mrs Dora Gregory
 (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) suicide
 (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?
7616 (Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature Hubert Randall (M. D. or other) MD
 Address Raymondville Mo Date signed 10-25-40

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

RECEIVED

District Health Officer No. 5,

District File Number. 1190128

Date Filed

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26897

Registration District No. 1191

Primary Registration District No. 6140

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Jackson T.P.
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Frankie Ambern

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, divorced, married, _____

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)

8. AGE: Years 95 Months 9 Days 20 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 _____
14. Maiden name MARYAN SHIDER
15. Birthplace Penn.
(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) Apr 14-1941 (b) Mrs Dora Gregory
(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.

20. DATE OF DEATH: Month Oct day 20
year 1940 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 _____

Due to _____
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? _____

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

23. Signature Leslie Randall (M. D. or other) _____
Address Licking Mo Date signed _____

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

SUPPLEMENTARY

