

DEC 14 1940

Registration District No. 47 Primary Registration District No. 4027 Registrar's No. 20

1. PLACE OF DEATH:

(a) County Betha
(b) City or town Adrian
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Adrian, Missouri
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days) 6 Mo

3. (a) PRINT FULL NAME DIXIE LEE MONGOMERY

3. (b) If veteran, name war _____ 3. (c) Social Security No. 26 4488

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

6. (b) Name of husband or wife Harry W. Montgomery 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 11 1875
(Month) (Day) (Year)

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

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

10. Usual occupation Housewife

11. Industry or business None

12. Name James Stephens

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

14. Maiden name Melba K. Powell

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

16. (a) Informant Orville Manning

(b) Address 3743 Washington N.C. Mo.

17. (a) Removal (b) Date thereof Oct-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rogers County

18. (a) Signature of funeral director J. Elliot

(b) Address 606 Independence Ave N.C. Mo.

19. (a) Dec 9-1940 (b) Othel C. Stephens
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cochran
(c) City or town Kennettville
(If outside city or town limits, write "RURAL")
(d) Street No. 4444 Walnut
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23
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 Oct 23 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery Disease Duration 3 days

Due to Coronary Arteriosclerosis

Due to Malnutrition (probably)

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

Major findings: Of operations none

Of autopsy none

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) no

(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? no

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

23. Signature E. E. Phelan (M. D. or other) M.D.

Address Adrian Mo Date signed 10-24

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

MOTHER FATHER

4p

RECEIVED

District Health Officer No. 7!

District File Number 12-40-1736

Date Filed 12-10-40

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.....
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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7
State File No. 38069

Registration District No. 47

Primary Registration District No. 4027

Registrar's No.

1. PLACE OF DEATH:
(a) County Bates
(b) City or town Bolivar
(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 Dipie Lee Montgomery
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 wid

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 Months Days If less than one day
65 2 13 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) (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. A.? _____ years.

20. DATE OF DEATH: Month Oct day 23 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 Pneumonia
N M D

Due to Cholelithiasis

Due to malignancy probably
N M D

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations 126

Of autopsy Cholelithiasis & pleural emphysema following pneumonia

22. If death was due to external causes, fill in the following: pneumonia

(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 E. E. Robinson (M. D. or other):
Address Adrian, Mo. Date signed _____

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

ROSENA MOORE

SUPPLEMENTAL

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

