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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FD JAN 25 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

42336

State File No.

Registration District No. 254

Primary Registration District No. 4154

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town Pattonsburg  
(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 40 YEARS 2 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Daviess  
(c) City or town Pattonsburg  
(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.

3. (a) PRINT FULL NAME Dora Lofland Ewing

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife C. B. Ewing 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased July 28 1873  
(Month) (Day) (Year)

8. AGE: Years 67 Months 4 Days 12 I hr. 30 P. M. min.

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

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

12. Name Joshua Lofland 7  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Wealthy Bugby  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant C. S. Hart  
(b) Address 383 Hargrave St Inglewood, Ca

17. (a) Burial (b) Date thereof 12/12/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation IOOF

18. (a) Signature of funeral director Steburner  
(b) Address Pattonsburg, Mo.

19. (a) 12-11-40 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10 year 1940 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov. 2, 1939, to Dec 8, 1940;  
that I last saw her alive on Dec 8, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of ascending colon Duration 10 mo.

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

Due to 46

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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 \_\_\_\_\_

(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? \_\_\_\_\_

220 While at work? \_\_\_\_\_ (Specify type of place)  
220 (e) Means of injury \_\_\_\_\_

23. Signature J R Knight (M.D. or other) DR  
Address Pattonsburg, Mo. Date signed 12-11-40

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

MOTHER FATHER

**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 G. S. Gromer.....

Licensed Embalmer No. 2857.....

P. O. Address Pattonsburg, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42336

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 25-4

Primary Registration District No. 418-4

Registrar's No. 19

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

1. PLACE OF DEATH:

(a) County Davess  
(b) City or town Pattonsburg  
(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)

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.

3. (a) PRINT FULL NAME Dora Lofland Ewing

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 n

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  
67 4 12 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) 12-11-1940 (b) E Schromer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 10  
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
that I last saw h..... 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 L R Knight (M. D. or other)

Address Pattonsburg Date 12/10/40

SUPPLEMENTAL

2019  
SUBBULHEMMENTARY