

FILED JAN 25 1949

Registration District No. **268**

Primary Registration District No. **5376**

Registrar's No. **87**

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

1. PLACE OF DEATH:
 (a) County Dent
 (b) City or town Rural Norman Twp
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
XX
(If not in hospital or institution, write street number or location)
XXXXXX
 (d) Length of stay: In hospital or institution XXXXXX
(Specify whether
 In this community all her life
years, months or days) 2

3. (a) PRINT FULL NAME Mary Ellen Flett
3. (b) If veteran, name war X **3. (c) Social Security** No. X

4. Sex female **5. Color or race** white **6. (a) Single, widowed, married, divorced** infant
6. (b) Name of husband or wife X **6. (c) Age of husband or wife if alive** X years
7. Birth date of deceased Nov 14 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
-		<u>1</u>	<u>5</u>	hr. min.

9. Birthplace Dent Co Norman Twp Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation X ?

11. Industry or business X 0

MOTHER FATHER
12. Name: Angus Flett D
13. Birthplace: Dent Co Mo D
(City, town, or county) (State or foreign country)

14. Maiden name Alma Ladwin
15. Birthplace: Dent Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Angus Flett
(b) Address Salem Mo

17. (a) Cause of death 12/21/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation County Cem

18. (a) Signature of funeral director [Signature]
(b) Address Salem Mo

19. (a) Date received local registrar Dec 29 1940 **(b) Registrar's signature** [Signature]

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Dent
 (c) City or town Rural Norman Twp
(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. 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20
 year 1940 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from Dec 19, 1940, to Dec 19, 1940;
 that I last saw her alive on Dec 19, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchi pneumonia 4 days
 Duration

Due to _____

Due to _____

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

PHYSICIAN
 Major findings: _____
 Of operations: _____
 Of autopsy: _____
 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? 240

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

23. Signature P. E. Griffith, M.D. (M. D. or other) [Signature]

Address Salem, Mo Date signed 12/21/40

107A

RECEIVED

District Health Officer No. 5,

District File Number 14163

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 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. 42368

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 269

Primary Registration District No. 3376

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Sassman Twp.
(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

Mary Ellen Flett

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced inf

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

Months

Days

If less than one day _____

1

5

_____ 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 _____

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.

DECLARATION OF PHYSICIAN

20. DATE OF DEATH: Month Dec day 20
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 Broncho Pneumonia
no preceding illness
unless it was a
common cold.

Duration

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?

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

23. Signature G.E. Felt (M. D. or other) _____
Address Sassman Twp. Date signed 7/1/41

SUPPLEMENTAL

