

FILED JAN 21 1941

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43309

State File No.

Registrar's No.

Registration District No. 608

Primary Registration District No. 5807

1. PLACE OF DEATH:

(a) County Newton
 (b) City or town Stella Mo
 (c) Name of hospital or institution: Cardwell Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution few days
 (Specify whether
 In this community
 years, months or days)

3. (a) PRINT FULL NAME

Helma Jonetta Cash

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

Married

6. (b) Name of husband or wife

Claver Cash

6. (c) Age of husband or wife if

alive 41 years

7. Birth date of deceased

Feb 29 - 1916
(Month) (Day) (Year)

8. AGE:

Years

Months

Day

If less than one day

2496

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

W. A. Gideon

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

Flourance Russell

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

W. A. Gideon

(b) Address

Anderson Mo Rt 3

17. (a)

Funeral
(Burial, cremation, or removal)

(b) Date thereof

12-7-40
(Month) (Day) (Year)

(c) Place: burial or cremation

Tracy Cemetery

18. (a) Signature of funeral director

Chas. W. Wilton

(b) Address

Stella Mo

19. (a)

12-16-40
(Date received local registrar)

(b)

Ada Collinge
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County McDonald
 (c) City or town Anderson Mo Rt 3
 (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 Dec day 5
 year 1940 hour 7 minute 40 P. M.

21. I hereby certify that I attended the deceased from Nov-24
 1940 to Dec-5, 1940
 that I last saw her alive on Dec 5, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death

Pregnancy
Rupture of stomach
 Due to _____
 Due to _____

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?

While at work?

(Specify type of place) _____
 (e) Means of injury _____
 23. Signature Cardwell (M. D. or other) _____
 Address Stella Mo Date signed 12/16/40

Duration

3 Months

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6,

District File Number 141-104

Date Filed JAN 13 1941

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. 43309

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 608

Primary Registration District No. 5807

Registrar's No.

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

1. PLACE OF DEATH:

(a) County De Witt

(b) City or town Stella
(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 Thelma Jenette Cash

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 W

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

24 9 6 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) _____ (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) _____ (b) _____
(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 Dec day 5
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 Pregnancy
Rupture of Stomach
Genitival Vomiting
N.M.D.

Due to _____

Due to _____

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

144 W

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? _____

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

23. Signature Chardull (M. D. or other) _____
Address Stella Mo. Date signed 4/21/40

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-43309