

No. 2  
-11-10-39  
5-17-39  
P I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
1940 FEB 25

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

4653

State File No. \_\_\_\_\_

Registration District No. 065

Primary Registration District No. 6143

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Texas

(b) City or town Rural Cass  
(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 36- years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State mo (b) County Texas / 07

(c) City or town Rural / 0  
(If outside city or town limits, write "RURAL")

(d) Street No. Cass / 0  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** Eliza Jane Foster

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. Old age pension

4. Sex F. 5. Color or race w.

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

6. (b) Name of husband or wife Henry 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 25- 1866  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 3 year 4 hour 30 minute 9 P.M.

21. I hereby certify that I attended the deceased on Jan 2 1941, 19\_\_\_\_, to\_\_\_\_, 19\_\_\_\_; that I last saw h\_\_\_\_\_ alive on\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>5-</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death Hypertensive Ht. Disease

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

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

Other conditions bronchial Asthma  
(Include pregnancy within 3 months of death)

Duration ?

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Housewife

11. Industry or business unknown

12. Name Charles Lewis

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

14. Maiden name Mary Mary

15. Birthplace \_\_\_\_\_  
(City, town, county) (State or foreign country)

16. (a) Informant Mrs Charles Harlett  
(b) Address Elk Creek mo.

17. (a) Burial (b) Date thereof Jan 4 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Steeley Chapel

18. (a) Signature of funeral director Daymond V. Elliott  
(b) Address Labool mo

19. (a) Jan 15 1941 (b) Mrs Lora McMillin  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_

23. Signature Laura Hoff MD (Aff. D. of officer) / 0  
Address Labool mo Date signed 1/2/40

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

RECEIVED

District Health Officer No. 5,

District File Number 24/105-

Date Filed 1/1

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**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.**