DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

APR 7 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12260

Registration District No. 840 Primary Registration District No. 6102 Registrar's No. 16

1. PLACE OF DEATH
(a) County Stoddard Dwelling
(b) City or town Puxico Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 26 year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard
(c) City or town Puxico Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Route 2.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Alvira L. Bess
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 C. C. Bess
6. (c) Age of husband or wife if alive 1870 years
7. Birth date of deceased Mar. 2 1941 (Month) (Day) (Year) 20 1870
8. AGE: Years 70 Months 7 Days 10 If less than one day hr. min.
9. Birthplace Boonville Ind. (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Sarah Birch
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant's own signature X C. C. Bess
(b) Address Puxico, Mo. Rural
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3 1941 (Month) (Day) (Year)
(c) Place: burial or cremation Rock Hill Cem.
18. (a) Signature of funeral director none
(b) Address
19. (a) 3-5-1941 (Date received local registrar) (b) Demain Dysart (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2nd day March year 1941 hour 10 minute 45 A. M.

21. I hereby certify that I attended the deceased from Feb 27, 1941, to March 2, 1941, that I last saw her alive on March 2, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia following Flu	
Due to ✓	
Due to ✓	
Other conditions ✓ (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓	
Of autopsy no	

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

23. Signature E. L. Elmore (M. D. or other)
Address Puxico Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very in

Rev. 5-17-39 1 X19511

RECEIVED
District Health Officer No. 2,
District File Number 41-403
Date Filed 9/4/41

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.

S. No. 2B
0—4-25-41
I X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12260

Registration District No. 840 Primary Registration District No. 6102 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Stoddard
(b) ~~City or town~~ Duck Creek T.P
(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)

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) Citizen of foreign country (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alvira L. Bess
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 M
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 70 Months 7 Days 10 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah Buck
15. Birthplace Unknown (City, town, or county) Unknown (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) 6-9-41 (Date received local registrar) (b) De Maris Dysart (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2 year 1941 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.

	Duration
Immediate cause of death	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature E. L. Elmore (M. D. or other)
Address Pupico Mo. Date signed

SUPPLEMENTARY