

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19155

Registration District No. 806

Primary Registration District No. 4485

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Schuyler
 (b) City or town Queens City, MO
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Schuyler
 (c) City or town Queens City, MO
(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

In this community _____ years, months or days (Specify whether)
3. (a) PRINT FULL NAME Effie J Cox
3. (b) If veteran, name war None **3. (c) Social Security No.** ✓
4. Sex Female **5. Color or race** White
6. (b) Name of husband or wife deceased **6. (c) Age of husband or wife if alive** deceased years
7. Birth date of deceased Feb 29 1864
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 20
 year 1941 hour 11 minute 25 P.M.
21. I hereby certify that I attended the deceased from Mar 16, 1940 to May 20, 1941,
 that I last saw her alive on May 20, 1941
 and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 2 Days 21 If less than one day _____ hr. _____ min.

Immediate cause of death Mitral leak
 Due to Arterio sclerosis Duration 6 wks
 Due to _____
 Other conditions 92 lb
(Include pregnancy within 3 months of death)

9. Birthplace Bloomfield Iowa
(City, town, or county) (State or foreign country)
10. Usual occupation House wife
11. Industry or business same
MOTHER FATHER
12. Name W. E. Dattin
13. Birthplace Dorsetshire England
(City, town, or county) (State or foreign country)
14. Maiden name Sarah D. Batta
15. Birthplace Lawrenceburg Indiana
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Myrna Cox Lauer
(b) Address Queens City MO
17. (a) Burial **(b) Date thereof** May 22 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bloomfield Iowa
18. (a) Signature of funeral director W. M. M. Orest
(b) Address Queens City MO
19. (a) 5/21-1941 **(b) O. P. Jones, Deputy**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accidental, 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) _____
 Means of injury _____
23. Signature O. P. Jones (M. D. or other) DO
Address Queens City **Date signed** May 21 1941

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 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

100-6-17-39 I 11251

AUG 8 1941

RECEIVED

District Health Officer No. 10

District File Number 6-41-1154

Date Filed JUN 18 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 myself

....., Registered Apprentice No.....
working under my personal supervision.

Signed Wm M West

Licensed Embalmer No. 2882

P. O. Address Greencity 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, above space should be left blank.