

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35140**

FILED NOV 21 1941

Registration District No. **384**

Primary Registration District No. **5539**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Howell Spring Creek Twp.**
(b) City or town **Pattonville Mo**
(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 **24 yrs** (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME **Dorothy Belle Fay**
3. (b) If veteran, name war **✓**
3. (c) Social Security No. **✓**

4. Sex **71** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **1m**
6. (b) Name of husband or wife **Rhuben Fay** 6. (c) Age of husband or wife if alive **28** years
7. Birth date of deceased **1-10-1917** (Month) (Day) (Year)

8. AGE: Years **24** Months **8** Days **2** If less than one day hr. min.

9. Birthplace **Ozark Co., Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Faul Riley**

13. Birthplace **10 Mo.** (City, town, or county) (State or foreign country)

14. Maiden name **Lebubler**

15. Birthplace **Howell Co., Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **F. Fay**

(b) Address **Pattonville, Mo**

17. (a) **15** (b) Date thereof **9-13-41** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lebubler**

18. (a) Signature of funeral director **Kobner**

(b) Address **West Plains Mo**

19. (a) **10-2-41** (b) **Vida W. Sinton** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Howell**
(c) City or town **Pattonville** **046**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **12**
year **1941** hour **10** minute **10** M.

21. I hereby certify that I attended the deceased from **9-2-41** 19. to **9-12-1941**
that I last saw her alive on **9-2-41** 19. and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of uterus**

Due to **Inversion of uterus following myoperium**

Due to **H & B**

Other conditions (Include pregnancy within 3 months of death) **H & B**

Major findings: **10-4-40 of Benard Cancer**
Of operations **Hoop, St Louis, Mo.**
Of autopsy **none**

Duration

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 **0**

23. Signature **L. Claude Bohrer** (M. D. or other) **Mo**
Address **West Plains Mo** Date signed **9-24-41**

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

RECEIVED

District Health Officer No. 5,

District File Number 11412069

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.