

FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35205

Registration District No. 408

Primary Registration District No. 3020

Registrar's No. 159

1. PLACE OF DEATH:

(a) County Jasper
 (b) City or town Carthage City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1102 W. Chestnut St.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 4 1/2 Years /

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 043
 (c) City or town Carthage /
 (If outside city or town limits, write "RURAL") 3
 (d) Street No. 1102 Chestnut St.
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____ 0

3. (a) PRINT FULL NAME Linnie Denella Stout

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 14, 1912
 (Month) (Day) (Year)

8. AGE:		Years	Months	Days	If less than one day
		<u>29</u>	<u>9</u>	<u>12</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Frank Watkins

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

14. Maiden name Bertha Coiner

15. Birthplace X Ill.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Watkins

(b) Address 1102 W. Chestnut St. Carthage, Mo.

17. (a) Burial (b) Date thereof 10-28-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer

(b) Address 1208 Garrison Ave., Carthage, Mo.

19. (a) Oct. 27 1941 (b) E. J. McEntire, M.D.
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26th,
 year 1941 hour 1:25 minute P. M.

21. I hereby certify that I attended the deceased from October 5
 1941 to October 26, 1941;
 that I last saw her alive on October 26, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma / Duration 9 yrs

Due to _____

Due to _____

Other conditions due to instrumental delivery 9 yrs ago
 (Include pregnancy within 3 months of death) severe lacerations

Major findings: of uterus which was not repaired
 Of operations was not done to my knowledge.

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 _____

Signature E. D. Hatcher (M. D. or other) _____

Address 403 1/2 S. Main Date signed Oct 27 1941

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

41-11-914

STATE OF NEW YORK DEPARTMENT OF HEALTH

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..... *Edmund*

Licensed Embalmer No. *222*

P. O. Address..... *Ortberg*

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.

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STANDARD CERTIFICATE OF DEATH

State File No. 35205
Registrar's No. _____

Registration District No. 408

Primary Registration District No. 3020

1. PLACE OF DEATH:

- (a) County Gasper
 - (b) City or town Carthage
(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

Linnie D. Stout

- 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 9

- 6. (b) Name of husband or wife _____
- 6. (c) Age of husband or wife if alive _____ years

- 7. Birth date of deceased Jan 14 1942
(Month) (Day) (Year)

- | | | | | |
|---------|--------------------|--------------------|-------------------|------------------------------------|
| 8. AGE: | Years
<u>29</u> | Months
<u>9</u> | Days
<u>13</u> | If less than one day
_____ min. |
|---------|--------------------|--------------------|-------------------|------------------------------------|

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

- 10. Usual occupation _____

- 11. Industry of 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)

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month Oct Year 1941 hour _____ minute _____ M.

- 21. I hereby certify that I attended the deceased from _____ 19 _____; that I last saw him/her alive on _____ 19 _____; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus
Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 5 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? _____

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

- 23. Signature E. D. Fatcher (M. D. or other) _____

Address 403 1/2 S. Main Date signed Dec 10

Carthage Mo-41

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

SUPPLEMENTARY

S-35205