

No. 2
13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39669

FILED DEC 11 1941

State File No.

Registration District No. 837

Primary Registration District No. 4508

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Bloomfield *Tim*

(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 _____

In this community Years 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard ¹⁰³

(c) City or town Bloomfield ²

(If outside city or town limits, write "RURAL") ⁰

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Sophie V. Phelan

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 Widow

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

7. Birth date of deceased Jan. 29, 1857 (Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Ruben W. Owen

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

14. Maiden name Mary Jane White

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

16. (a) Informant Thurmena Phelan

(b) Address Bloomfield, Missouri

17. (a) Burial (b) Date thereof 10-26-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomfield Cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) _____ (b) _____ (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24 year 1941 hour 4 minute 15 A.M.

21. I hereby certify that I attended the deceased from 10-22 1941 to 10/24 1941; that I last saw her alive on 10-27 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis of the left carotid.

Due to ✓

Due to ✓

Other conditions (Include pregnancy within 3 months of death) 468

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? _____

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

23. Signature S. S. Owen (M. D. or other) _____

Address Dept. 410 Date signed 10/24/41

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1241-1669

Date Filed 12/10/41

RECEIVED RECORDS

RECEIVED

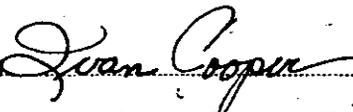
STATEMENT BY LICENSED EMBALMER

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. 4119

working under my personal supervision.

Signed



..... Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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, fact should be so stated above.

STANDARD CERTIFICATE OF DEATH

State File No. 39669

Registration District No. 837

Primary Registration District No. 4508

Registrar's No.

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Warsfield
(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 Laphie V. Pletan

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced W.

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

7. Birth date of deceased Jan 29 1904
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 8 (If less than one day hr. min.)

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

10. Usual occupation

11. Industry of business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Bloomfield Cemetery

18. (a) Signature of funeral director Chicklund Co.

(b) Address Bloomfield Cemetery

19. (a) Nov-13-41 (b) Pearl E. Etniore
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day Year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 that I last saw him alive on 19 and that death occurred on the date and hour stated above. Immediate cause of death

Duration

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?

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

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

