

S. No. 2  
M-1-4-41  
v. 5-17-39  
I X26390

42022

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

JAN 8 1942

Registration District No. 403

Primary Registration District No. 5557

48  
0  
0

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural - Brookings Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Residence  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days) 4.5 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Hickman Mills - Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 87th St & Raytown Rd.  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Murphy Bell Erwin

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov - day 18 year 1941 hour 7 minutes 30 M.

21. I hereby certify that I attended the deceased from July 1940 to Nov 18 1941.  
that I last saw her alive on Nov 16 1941 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color of hair White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wallace Erwin 6. (c) Age of husband or wife if alive 75 years (Day) 1873 (Year)

7. Birth date of deceased: July (Month) 6th (Day) 1873 (Year)

8. AGE: Years	Months	Days	If less than one day
<u>68</u>	<u>4</u>	<u>12</u>	hr. _____ min. _____

Immediate cause of death Acute cardiac failure Duration 1 hr.

Due to Ch. valvular heart disease

Due to Cachexia

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 938

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Lawrence

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

14. Maiden name unknown

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

16. (a) Informant Wallace Erwin

(b) Address Hickman Mills Mo.

17. (a) Erwin Cemetery (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, ~~cremation~~)

(c) Place: burial or cremation Erwin Cemetery

18. (a) Signature of funeral director Fields Funeral Home

(b) Address Lee Summit miss.

19. (a) 11-21-41 (Date received local registrar) (b) MMebank (Registrar's signature)

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 MMebank (M. D. or other) MD

Address Raytown Mo Date signed 11/21/41

365 (Licensed Embalmer's Statement on Reverse Side)

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**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.....

*P. C. Fields*

Licensed Embalmer No. *2957*

P. O. Address.....

*Luis Summit 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.**