

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 19

1. PLACE OF DEATH:
(a) County Howard
(b) City or town Fayette
(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 years, months or days)

3. (a) PRINT FULL NAME Mrs Emma Coombe,
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 Widowed
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased February 27th 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 0 17 hr. min.

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

10. Usual occupation At home

11. Industry or business.....

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Frank Coombe,

(b) Address Fayette, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-43
(Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Guy T. Halley.

(b) Address Fayette, Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Howard, 45
(c) City or town Fayette (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 March day 14
year 1943 hour 5 minute 2 M.

21. I hereby certify that I attended the deceased from February 23
1943, to March 14, 1943
that I last saw her alive on March 14, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Uremic Coma 3 days

Due to Chronic Cardiac - 5 yr
Vascular - Renal disease

Other conditions Acute influenza 2 wks
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy..... 13/A

Duration
3 days
5 yr
2 wks
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 W. Bloom (M. D. or other) MS
Address Fayette Mo Date signed 3-18-43

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 4-9-43

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

Guy T. Hesser

Licensed Embalmer No.

2964

P. O. Address

Fayette Tenn

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10372

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Seyette
(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 Mrs Emma Coombe

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 W

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

7. Birth date of deceased Feb 27 (Month) (Day) (Year)

8. AGE: Years 86 Months 0 Days _____ (If less than one day _____ 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 _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-18-43 (Date received local registrar) (b) Ernest W. Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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 Memorie come 3 days

Due to Chromi Cardis 5 yrs
Arterio Sclerotic disease

Due to _____

Other conditions Acute Influenza 2 wks
(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

MOTHER FATHER

SUPPLEMENTARY 14

