

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Boone  
(b) City or town Quinn Station Twp.  
(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 Mo (b) County Boone  
(c) City or town Quinn Station Twp.  
(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 \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Month 11 day 18  
year 1943 hour 6 minute 30 A.M.  
21. I hereby certify that I attended the deceased from 1940  
19\_\_\_\_ to Nov. 18, 1943  
that I last saw her alive on Nov. 18, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myx edema  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Major findings: \_\_\_\_\_  
Of operations 93d  
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 [Signature] (M. D. or other)  
Address Centrolia Mo Date signed 11/18/43

3. (a) PRINT FULL NAME IDA MAY STEELE

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

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

(b) Name of husband or wife John M. Steele 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased \_\_\_\_\_ (Month) 7 (Day) 4 (Year) 1867

8. AGE: Years 76 Months 4 Days 14 hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

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

12. Name Joseph Steele

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

14. Maiden name Parish

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

16. (a) Informant John M. Steele

(b) Address Centrolia Mo

17. (a) Burial (b) Date thereof 11-21-43 (Month) (Day) (Year)

(c) Place: burial or cremation Centrolia Mo

18. (a) Signature of funeral director [Signature] (b) Address Centrolia Mo

19. (a) 11/20-1943 (b) Ma. Arch. Plangier (Date received local registrar) (Registrar's signature)

1019

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

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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 *M. McAdams*.....

Licensed Embalmer No. 4313.....

P. O. Address Centralia 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.**