

No. 12-45
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24741

FILED AUG 12 1946

State File No. _____

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 213

1. PLACE OF DEATH

(a) County St. Francois
(b) City or town Leadington, Mo.
(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. Elsie Dalton

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 married

6. (b) Name of husband or wife Mr. Walter Dalton 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Sept. 25 1892
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 10 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Mrs. Lee Moore

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

14. Maiden name Miss Addie Calvert

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

16. (a) Informant Mr. Walter Dalton (Husband)

(b) Address Leadington, Mo.

17. (a) Burial (b) Date thereof July 7-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park View C. Farmington, Mo.

18. (a) Signature of funeral director Alvin W. Hood

(b) Address 303 Crane St. St. Louis, Mo.

19. (a) 7-11-46 (b) Ether R. Rudloff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Leadington, Missouri
(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 7 day 5
year 1946 hour 2 minute 50 M.

21. I hereby certify that I attended the deceased from July 7-5 1946 to July 7-5 1946
that I last saw her alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma ovary & uterus Duration week

Due to _____

Due to _____

Other conditions See answers
(Include pregnancy within 3 months of death)

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 N O Raabe (M. D. or other)

Address Leadington, Mo. Date signed 7-9-46

289 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 846-245

Date Filed 8-9-46

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 Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address 303 Crane St. Flat Room

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.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Francois
 (b) City or town Leadington
(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

3. (a) PRINT FULL NAME Elsie Dalton
 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 Mar

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Sept 25 1891
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 2
(If less than one day, hr. min.)

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

10. Usual occupation Genl

11. Industry or 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 _____
(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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 1 Year 1946 Hour _____ minute _____ M.

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

Due to myself of cancer
Roadway

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

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

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

23592

SUPPLEMENTARY

24741