

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29473

State File No. \_\_\_\_\_

**FILED** OCT 1 1946  
Registration District No. 11

Primary Registration District No. 4028

Registrar's No. 60

**1. PLACE OF DEATH:**

(a) County Barry Co.  
 (b) City or town Exeter  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (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 Missouri (b) County Barry  
 (c) City or town Exeter  
 (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** ADA DELL  
**3. (b) If veteran,** \_\_\_\_\_ **3. (c) Social Security** \_\_\_\_\_  
 name war \_\_\_\_\_ No \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Sept day 11  
 year 1946 hour \_\_\_\_\_ minute 7:30 PM.

**4. Sex** female **5. Color or** white **6. (a) Single, widowed, married,** married  
 race white divorced \_\_\_\_\_  
**6. (b) Name of husband or wife** Wm Dell **6. (c) Age of husband or wife if** \_\_\_\_\_  
Sept 23 1885 alive \_\_\_\_\_ years  
 (Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from** Feb 13 1945 to Sept 11 1946  
 that I last saw her alive on Sept 11 1946  
 and that death occurred on the date and hour stated above.

**7. Birth date of deceased** Sept 23 1885  
 (Month) (Day) (Year)

**8. AGE:** Years 60 Months 11 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cervical Carcinoma Duration 9 Mo.

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

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

**10. Usual occupation** housewife

Major findings: 48A  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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

**12. Name** Wm Dell 9  
**13. Birthplace** DK (City, town, or county) (State or foreign country)

**14. Maiden name** DK  
**15. Birthplace** DK (City, town, or county) (State or foreign country)

**16. (a) Informant** Wm Dell  
**(b) Address** Exeter Mo

**17. (a)** Burial **(b) Date thereof** Sept 13 1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** map. Rowland-Exeter

**18. (a) Signature of funeral director** Carroll  
**(b) Address** Carroll

**19. (a)** Sept 26-1946 Grace Williams  
 (Date received local registrar) (Registrar's signature)

**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? \_\_\_\_\_

**23. Signature** Carroll ABW  
 Address Carroll, Mo Date signed 9/14/46

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

5  
6  
0

RECEIVED

District Health Officer No. 6,

District File Number 946-993

Date Filed SEP 30 1946

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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 G. E. Culver

Licensed Embalmer No. 3584

P. O. Address Cassville, 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.**