

JUN 14 1940  
Registration District No. 735

Primary Registration District No. 2034

Registrar's No. 109

1. PLACE OF DEATH:

(a) County Randolph  
(b) City or town Osage  
(c) Name of hospital or institution: Woodland  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days) 11/3

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph  
(c) City or town Jacksonville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

8. (a) PRINT FULL NAME DETAXIA AGNES SHIFLETT

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife B. H. Shiflett 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 28 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
60 0 22 hr. 0 min.

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

10. Usual occupation Housewife

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

12. Name Woodson White

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

14. Maiden name Mary White

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

16. (a) Informant's own signature Mr. B. H. Shiflett

(b) Address Cairo, Mo

17. (a) Burial (b) Date thereof May 22 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Huntville, Mo

18. (a) Signature of funeral director Tom B. Patton

(b) Address Huntville, Mo

19. (a) Ms 422-40 (b) Carl Williams  
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month May day 20  
year 1940 hour 16:05 minute 0 A. M.

21. I hereby certify that I attended the deceased from May 17  
\_\_\_\_\_, 1940, to May 20, 1940;  
that I last saw her alive on May 20, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Duration one week

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

Other conditions \_\_\_\_\_  
(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? 005

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Carl Williams (M. D. or other) MD

Address Osage, Mo Date signed May 22/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

109

RECEIVED

District Health Officer No. 10

District File Number 6-40-1157

Date Filed JUN 10 1940

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 Paul J. Patton

Licensed Embalmer No. 4095

P. O. Address Hunterth, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19321

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 735

Primary Registration District No. 2034

Registrar's No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD  
MOWENA MOORE

1. PLACE OF DEATH:

(a) County Randolph  
(b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Octavia Agnes Shiflett

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

(c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

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

8. AGE: Years Months Days If less than one day  
60 0 22 hr. min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

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) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration \_\_\_\_\_

Due to lobar pneumonia

Due to Septicemia

Other conditions (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) \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature Thos J Flemming (M. D. or other)

Address Moore Date signed \_\_\_\_\_

SUPPLEMENTARY

140.

S-19321