

SEP 24 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29138
Do not use this space.

1. PLACE OF DEATH
 (a) County Monteau 2 Registration District No. 575
 (b) Township Willow Fork 0 Primary Registration District No. 4339
 (c) City Dipton (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Josephine Reidy
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-8-1881

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>59</u>	<u>11</u>	<u>24</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at Home
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cooper County Mo.

FATHER
 13. NAME Daniel Reidy
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland 5

MOTHER
 15. MAIDEN NAME Mary Kane
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland 5

17. INFORMANT (ADDRESS) Kora Reidy Dipton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE California Mo. DATE 9-3-1940

19. FUNERAL DIRECTOR (ADDRESS) J. G. Ambroff Dipton Mo. 507

20. FILED 9-3-1940 Mrs. Sarah J. [unclear] Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-2-1940

22. I HEREBY CERTIFY, That I attended deceased from 1-1-1940, 19____ to 9-2-1940, 19____
 I last saw her alive on 9-2-1940, 19____. Death is said to have occurred on the date stated above, at 12:50 P.M. A.M.
 The principal cause of death and related causes of importance were as follows:
Acute Infective Endo-Carditis
a sequel of Arthritis
 Other contributory causes of importance: sequelae of Hepatitis, General Anasarca

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) J. B. Norman, M. D.
 (Address) Dipton Mo.

Date of onset

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.

STATEMENT BY LICENSED EMBALMER

I, Louis G. Ambroff, Licensed Embalmer No. 376
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Louis G. Ambroff
..... L. E.
No. or by, Registered Apprentice No.
working under my personal supervision.
Signed Louis G. Ambroff
Licensed Embalmer No. 376

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.)

No. 2B
2-21-40
P1 X22639

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29138**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **575**

Primary Registration District No. **4339**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County... **Moniteau**
(b) City or town... **Lepton**
(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...
In this community... (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Josephine Reidy

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... **S**
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 **59** Months **11** Days **24** If less than one day hr. min.

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

10. Usual occupation...

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) (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) (Date received local registrar) (b) **Mrs. C. E. Frye** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State... **Mo.** (b) County... **Moniteau**
(c) City or town... **Mo.** (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

20. DATE OF DEATH: Month **9** day **2** year **1940** hour minute M.

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

Due to...
Due to...
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? While at work (Specify type of place) (e) Means of injury.

23. Signature... **B. Norman** (M. D. or other) Address... **Lepton Mo.** Date signed...

SUPPLEMENTAL

