

SEE EMBALMING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2229
Registrar's No. 86825

Registration District No. 668

Primary Registration District No. 3082

1. PLACE OF DEATH:

(a) County Wagoner
(b) City or town Pettis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Northwestern Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days
(Specify whether
In this community Hospital
years, months or days)

8. (a) PRINT FULL NAME ANDREY-PAULINE

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

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (c) Age of husband or wife if alive 38 years
7. Birth date of deceased 1-2-1912
(Month) (Day) (Year)

8. AGE: Years 27 Months 1 Days 18
If less than one day hr. min.

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

10. Usual occupation Nurse

11. Industry or business

MOTHER FATHER { 12. Name B. F. Bowline M.D.
13. Birthplace Ursulles Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Philippa
15. Birthplace Ursulles Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature B. F. Bowline M.D.
(b) Address Ursulles Mo.

17. (a) Ursulles (b) Date thereof 1-22-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ursulles Mo.

18. (a) Signature of funeral director Ursulles Mo.
(b) Address Ursulles Mo.

19. (a) Jan 21, 1946 (b) Mrs. Harry Sward
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery
(c) City or town Joplin
(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 Jan day 21st
year 1946 hour 6: minute 42 M.

21. I hereby certify that I attended the deceased from 1-2-40
to 1-1-46, 1940

that I last saw him alive on 1-1-46, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Shock from
Laparotomy

Due to Pelvic abscesses Duration 1 mo

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 2 large abscesses
Of operations of both tubes & ovaries
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 Dr. J. S. Sward (M. D. or other)
Address Ursulles Mo. Date signed Jan 21, 1946

RECEIVED
DISTRICT HEALTH OFFICER NO. 8,
District File Number
41140
the Filed

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 James E. Richards
Licensed Embalmer No. 2466
P. O. Address Tipton 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3329
Do not use this space.

1. PLACE OF DEATH

(a) County Pettis Registration District No. 668
(b) Township Sedalia Primary Registration District No. 3032 Registered No. _____
(c) City Sedalia (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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

(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
27 1 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 - 2, 1940

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw him alive on 19 Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Shot from Laparotomy
Pettis abscess
13410

Other contributory causes of importance:

2 large abscesses, both
tuberc. & ovaries
not gonococcic origin

Name of operation probably Strep Date of 1940

What test confirmed diagnosis? Was there postmortem?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Abortion, seasonal 19

Where did injury occur? month (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

was beginning

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) D. P. Dyer M. D.

(Address) Sedalia mo

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