DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2912

Registration District No. 574 Primary Registration District No. 4338 Registrar's No.

WRITE PLAINLY—USE UNFADING 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.

1. PLACE OF DEATH:
(a) County MONITEAU
(b) City or town JAMESTOWN 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)
In this community 81 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Moniteau
(c) City or town Jamestown 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.

3. (a) PRINT FULL NAME ELIZA ANN DEARING
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 widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 9 (Month) 23 (Day) 1860 (Year)
8. AGE: Years 81 Months 3 Days 12 If less than one day hr. min.
9. Birthplace Jamestown (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Hiram McDaniel
13. Birthplace Jamestown (City, town or county) Missouri (State or foreign country)

MOTHER
14. Maiden name A. Johnston
15. Birthplace (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Mrs H. O. Herndon
(b) Address Jamestown, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-41 (Month) (Day) (Year)
(c) Place: burial or cremation Union Cemetery
18. (a) Signature of funeral director C. Albert Hornbeck
(b) Address Prairie Home Mo.
19. (a) 1-17-1942 (Date received local registrar) (b) Grace Gentzsch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13 year 1942 hour 1 minute 30 A M.
21. I hereby certify that I attended the deceased from 1-8, 1942, to 1-13, 1942, that I last saw her alive on 1-8, 1942, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma	
Colon & Right Ovary & Fallopian tube	unknown
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? (Specify type of place)
While at work? (e) Means of injury /

23. Signature A. L. Wenneth M. D. or other
Address Prairie Home Mo Date signed 1-21-42

(Licensed Embalmer's Statement on Reverse Side)

Rev. 6-17-39 I X19511

2-11

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 C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home 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.

V. S. No. 2B
10M—8-21-41
I X29288

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STANDARD CERTIFICATE OF DEATH

State File No. 2912

Registration District No. 5 74

Primary Registration District No. 4338

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Monteau
(b) City or town Jamestown
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Eliza A. Dearing
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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 23 (Day) 1860 (Year)

8. AGE: Years 81 | Months 3 | Days 13 | If less than one day 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)
MOTHER
14. Maiden name
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) (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 him alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of right ovary & Fallopian tube	
Due to: Cancer of right ovary.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy #9 N

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 Dr. A. F. Meridith (M. D. or other)
Address Prairie Home, Mo. Date signed 3-5-1942

SUPPLEMENTARY