DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MAY 6 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16242

Registration District No. 816 Primary Registration District No. 4492 Registrar's No. 12

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Chaffee (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ✓ 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community 8 Months (Specify whether years, months or days) 232

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Francis

(c) City or town Farmington (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

8. (a) PRINT FULL NAME Emma Florence Estes

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 Widow

6. (b) Name of husband or wife Joseph Melvin Estes 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased June (Month) 6 (Day) 1857 (Year)

8. AGE: Years 82 Months 9 Days 24 If less than one day ___ hr. ___ min.

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

10. Usual occupation House Keeper

11. Industry or business ✓ O

MOTHER FATHER

12. Name Jim Cunningham

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

14. Maiden name Dont Know

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

16. (a) Informant's own signature J W Estes

(b) Address Chaffee Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Park view Farmington Mo

18. (a) Signature of funeral director Bishinghoff Hubbard

(b) Address Chaffee Mo

19. (a) 5-1-40 (Date received local registrar) (b) W O Finney (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 30 year 1940 hour 2 minute a M.

21. I hereby certify that I attended the deceased from 1-30-40, 19___, to 4-30, 1940; that I last saw her alive on 4-29, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Senility	
arterio sclerosis	20yr
Due to: Respiratory failure	
Due to: Probable Carcinoma Uterus	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 6
Of autopsy 4

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? 135

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

23. Signature W O Finney (M. D. or ~~Coroner~~)

Address Box Bldg Chaffee Mo Date signed 5-1-40

(Licensed Embalmer's Statement on Reverse Side)

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.

USE PERMANENT BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 2,
District File Number 540-992
Date Filed 5/6/40

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 Mamie Bienlienhoff

Licensed Embalmer No. 3242

P. O. Address Chaffee Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.