

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.

REC'D MAY 17 1938

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

15067  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Lafayette Registration District No. 460  
 (b) Township Dover Primary Registration District No. 5623  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (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 24 yrs. mos. ds. (f) How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. mos. ds.

**2. PRINT FULL NAME** Jessie A. Larkin

(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 <b>Female</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Widowed</b>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Mike Larkin Deceased</b>			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>June 17th 1873</b>			
7. AGE YEARS <b>64</b>	MONTHS <b>9</b>	DAYS <b>15</b>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>1</b>		
	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) <b>Cole Co. Mo.</b>			
FATHER	13. NAME <b>John A. Hunter</b>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Cole Co. Mo.</b>		
MOTHER	15. MAIDEN NAME <b>Elizabeth George</b>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Moniteau Co. Mo.</b>		
17. INFORMANT <b>Mrs. H. H. Lewis</b> (ADDRESS) <b>Dover, Mo.</b>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Higginsville</b> DATE <b>4/6/38</b> , 19__			
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <b>A. H. Hader Higginsville, Mo.</b>			
20. FILED <b>April 8 1938</b> <b>Tiffany Webb</b> Local Registrar			

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 4 1938**

22. I HEREBY CERTIFY, That I attended deceased from **Mar 18 1938** to **April 4 1938**  
 I last saw her alive on **April 7 1938** 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:

*cerebral apoplexy.*

Date of onset **3-25-38**

Other contributory causes of importance:  
*edema of lungs* **4-4-38**

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? **no**

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? **no**  
 If so, specify \_\_\_\_\_ (Signed) **A. D. Johnston**, M. D.  
**Carver, Mo.** (Address)

**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.....

Licensed Embalmer No. 3637

P. O. Address Higginsville, 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

15-067  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Lafayette Registration District No. 460  
 (b) Township Douze Primary Registration District No. 5673  
 (c) City ..... (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 Jessie A. Larkin  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid  
(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.  
64 9 17

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. cool miner  
 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED June 23, 1938 Jeffrey Webb Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 4, 1938

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

I last saw h..... 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:

Date of onset

Other contributory causes of importance:

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) A. D. Johnston, M. D.  
 (Address) Carder mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

