

REC'D MAY 24 1938

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

15648

Do not use this space.

APR 24 1938

## 1. PLACE OF DEATH

(a) County Randolph Registration District No. 733 5967  
 (b) Township Salt Springs Primary Registration District No. 4438 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. County Infirmary 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George W. White 332

(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 male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha White  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 23<sup>rd</sup> 1853  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 84 4 8  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
 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) MoFATHER 13. NAME Marion White14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KyMOTHER 15. MAIDEN NAME Sarah J. Brundage16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo17. INFORMANT (ADDRESS) Cecilia White Moberly Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Moberly Mo DATE Apr 3<sup>rd</sup> 193819. FUNERAL DIRECTOR (ADDRESS) W. A. T. Jones Moberly Mo20. FILED May 10 - 1938 Carl S. A. Barbour Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 1<sup>st</sup> 193822. I HEREBY CERTIFY, That I attended deceased from Jan 1 1938, to April 1 1938I last saw him alive on April 1<sup>st</sup> 1938. Death is said to have occurred on the date stated above, at 8:15 P. M.

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

Hypostatic PneumoniaDate of onset 3/27/38

Other contributory causes of importance:

Senility  
Arteriosclerosis  
Paralysis of lower extremities

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Examination 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) Dr. S. W. Jones M. D.(Address) Moberly Mo

874-

**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No. ....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by .....

L. E. ....

No. .... or by ....., Registered Apprentice No. ....

working under my personal supervision.

Signed .....

Licensed Embalmer No. ....

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

15-648 J  
Do not use this space.

1. PLACE OF DEATH

(a) County Randolph Registration District No. 733  
 (b) Township Salt Springs Primary Registration District No. 5969 Registered No. \_\_\_\_\_  
 (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 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
 (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.

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) Apr 1 1939

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:

Hypostatic Pneumonia Date of onset \_\_\_\_\_

Other contributory causes of importance:

Senility  
Arterio Sclerosis  
Paralysis of several yrs. starting

Name of operation \_\_\_\_\_ Date of operation \_\_\_\_\_  
 What test confirmed diagnosis? Autopsy 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) D. H. Johnston, M. D.

(Address) St. Louis

SUPPLEMENTARY

S-15648 1938