

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.

JAN 18 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

42987

Do not use this space.

1. PLACE OF DEATH

(a) County Independence
 (b) Township Independence
 (c) City Independence
 (e) Length of residence in city or town where death occurred 1125 yrs. mos. ds.

Registration District No. 288
 Primary Registration District No. 5406

Registered No. _____

(d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)

(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 Single (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 19/38

7. AGE YEARS 1 MONTHS 0 DAYS 0 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 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) Mo. Tenn.

FATHER 13. NAME Cigal Alexander

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

MOTHER 15. MAIDEN NAME Hors Edna Barrett

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

17. INFORMANT C. C. Barnett (ADDRESS) Seering, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Burial DATE Nov 19, 38

19. FUNERAL DIRECTOR (ADDRESS) Seering, Mo.

20. FILED 1-11 19 38 Seering, Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 19 19 38

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____

I last saw h. Still born, 19____ Death is said

to have occurred on the date stated above, at 8 P. 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? No

If so, specify _____

(Signed) Nancy Jones, M. D.

(Address) Seering, Mo.

RECEIVED

District Health Officer No. 3,

District File Number 39-116

Date Filed 1-11-29

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 comply with 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

42987
Do not use this space.

1. PLACE OF DEATH

(a) County Dunklin Registration District No. 288
(b) Township Independence Primary Registration District No. 3406
(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. Shelburn Alexander St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 19 - 1938
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.

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)

13. NAME

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

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 1-11- 1939 Shelburne Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 19 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) Shelburne M. D.

(Address) Remitt 2nd

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