

1938 JAN 24 1938

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

43278
Do not use this space.

1. PLACE OF DEATH

(a) County Howell Registration District No. 1110
 (b) Township Delaware Primary Registration District No. 5541
 (c) City Delaware Springs (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 ma 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 30 - 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 1 28

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. Farmer
 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) Howell Co., Mo.

13. NAME unk

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

15. MAIDEN NAME "

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

17. INFORMANT (ADDRESS) Carl Chapman
Delaware Springs Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Delaware Springs Mo
12-29-1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) None

20. FILED 12-30-1938 Mrs Gladys Foster
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-28-1938

22. I HEREBY CERTIFY, That I attended deceased from 4-20-1937, to 12-28-1938

I last saw him alive on 10-2-1938. Death is said to have occurred on the date stated above, at 6:00 P.M.

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

Chronic Mitral Insufficiency
Chronic Myocarditis
General Atherosclerosis
Hypertensive Myocarditis
 Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? Exam 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) E. C. Bohrer, M. D.
West Plains, Mo
 (Address) _____

WHITE PLAINLY, WITH UNFADING INK---THIS IS 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 X16025

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.....

P. O. Address.....

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.