

FEB 7 1939

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

2525
Do not use this space.

1. PLACE OF DEATH

(a) County Howell Registration District No. 388
 (b) Township Union Primary Registration District No. 5542 Registered No. _____
 (c) City Pomona, Mo. Rt. 1 Street No. _____
 (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)
310 Jas. Gardner Rider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ma 4. COLOR OR RACE whit 5. (SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)) Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-11-1937
 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. Child
 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.

FATHER 13. NAME Jas. R. Rider

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howell Co., Mo.

MOTHER 15. MAIDEN NAME Bertha Grant

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howell Co., Mo.

17. INFORMANT (ADDRESS) J. R. Rider Pomona, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (NAME) (ADDRESS) _____

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Jan. 28 1939 to Jan 31 1939
 I last saw him alive on Jan. 31 1939 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:

Broncho-pneumonia Date of onset Jan 24

Other contributory causes of importance:

Malnutrition

Name of operation _____ Date of _____
 What test confirmed diagnosis? Exam 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) E. R. Raper, M. D.

858 (Address) West Plains, Mo.

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.

107a

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.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
MEMPHIS, TENNESSEE

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25-25-
Do not use this space.

1. PLACE OF DEATH
 (a) County Howell Registration District No. 388
 (b) Township Sisson Primary Registration District No. 5542
 (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 Joe Gordon Rider
 (a) Residence, No. 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED mf
 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. ormin.
 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), 19.....
 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:
Broncho Pneumonia
following Influenza
 Date of onset Jan 23 1939
 Other contributory cause of importance:
admittation
Influenza
 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) E. Royce Bohrer, M. D.
 (Address) West Plains mo

SUPPLEMENT

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

REGISTRATION IS VERY IMPORTANT. CLASSIFICATION IS VERY IMPORTANT. LISTED STATISTICS. BE PROPERLY CLASSIFIED.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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25-25-
Do not use this space.

1. PLACE OF DEATH
 (a) County Howell Registration District No. 388
 (b) Township Siason Primary Registration District No. 3542
 (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 Joe Gordon Rider
 (a) Residence, No. 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Inf

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-11-1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
1 9 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child

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

FATHER 13. NAME Joe L. Rider
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

MOTHER 15. MAIDEN NAME Bertha Grant
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

17. INFORMANT (ADDRESS) J. L. Rider
Pomona mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Dripping Springs DATE Feb 1 1939

19. FUNERAL DIRECTOR Raige Robertson
 (ADDRESS) West Plains mo

20. FILED March 20 1939 Mo. Paul Cook
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 31 - 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-28 1939 to 1-31 1939
 I last saw him alive on 1-31 1939. Death is said to have occurred on the date stated above, at 11 P. m.
 The principal cause of death and related causes of importance were as follows:
Broncho Pneumonia Date of onset

Other contributory causes of importance:
malnutrition

Name of operation..... Date of.....
 What test confirmed diagnosis? exam 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) E. Rouse Baker, M. D.
 (Address) West Plains mo

REGISTERING SMALL FEE TO RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CROSS OR EXAMINE IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.