

REC'D FEB 27 1939

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

3195

Do not use this space.

## PLACE OF DEATH

(a) County New Madrid Registration District No. 603  
 (b) Township 1 Primary Registration District No. 4357 Registered No. \_\_\_\_\_  
 (c) City Morehouse (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 566 Verona D. Poyner

(a) Residence, No. Morehouse, Missouri 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

## MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 27, 19395A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas Poyner

I HEREBY CERTIFY That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 20, 1862Jan 15, 1939, to Jan 27, 19397. AGE YEARS 76 MONTHS 9 DAYS 7 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.I last saw h. \_\_\_\_\_ alive on Jan 26, 1939, 1939. Death is saidto have occurred on the date stated above, at 3:20 p. m.

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HousewifeAcute pulmonary nephritis! Date of onset \_\_\_\_\_

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 \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Henry County (STATE OR COUNTRY) Tennessee.FATHER 13. NAME Russell Cunningham14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) \_\_\_\_\_MOTHER 15. MAIDEN NAME Margaret James16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) \_\_\_\_\_17. INFORMANT Charles H. Poyner (ADDRESS) Morehouse, Missouri18. BURIAL ~~OR CREMATION~~ PLACE Memorial Park DATE January 28, 193919. FUNERAL DIRECTOR (NAME) H. J. Welsh (ADDRESS) Stanton, Missouri

20. FILED \_\_\_\_\_, 19\_\_\_\_ Local Registrar.

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

What test confirmed diagnosis Cholera 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? \_\_\_\_\_

If so, specify Howard M. King M. D.(Signed) S. K. Stanton (Address) \_\_\_\_\_

5:16

129

**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, \_\_\_\_\_

*Harvey S. Johnson*

or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

*Harvey S. Johnson*

Licensed Embalmer No. *3704*

P. O. Address *Sixteen, St*

**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

3195-  
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 3693  
(b) Township Morehouse Primary Registration District No. 4357 Registered No. ....  
(c) City Morehouse (d) Street No. ....  
(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. Verona D. Pryner  
(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (wid)

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.  
75- 9 7

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 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-27-1939

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 .

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

Acute Interstitial nephritis Date of onset 1937

Other contributory causes of importance: 131

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) Howard M. Kennedy, M. D.

(Address) Director M.D.

SUPPLEMENTARY

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

3125  
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 603  
(b) Township \_\_\_\_\_ Primary Registration District No. 4357 Registered No. \_\_\_\_\_  
(c) City Morehouse (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. Verona D. Payne 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wed (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-20-1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
75 9 7

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 18 20

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) Tenn

13. NAME Russell Cunningham

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

15. MAIDEN NAME Margaret James

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) None

17. INFORMANT (ADDRESS) Chas D. Payne  
Morehouse

18. BURIAL, CREMATION, OR REMOVAL

PLACE Memorial Park DATE 1-20-1939

19. FUNERAL DIRECTOR (ADDRESS) H. J. Welsh  
Atterton

20. FILED May 30 1939 Mrs John Parrish  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-27 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-15 1939 to 1-27 1939

I last saw h. alive on 26 1939 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:

acute interstitial ne  
phritis

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 \_\_\_\_\_, 1939

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) Howard M. Keady, M. D.

(Address) Atterton