

FEB 7 1939

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

3512  
Do not use this space.

1. PLACE OF DEATH *2*  
 (a) County *Phelps* Registration District No. *678*  
 (b) Township *St James* Primary Registration District No. *5904*  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered 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 *263 Glenn Deekard*  
 (a) Residence, No. *St James Mo* 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) *single*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *7-25-1907*  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *31 5 12*  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *founder*  
 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) *12-31-38* 11. Total time (years) spent in this occupation *10 7 2*  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Thunora Mo*  
 13. NAME *Chas Deekard*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Alton Mo*  
 15. MAIDEN NAME *Sarah Stevens*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Carter Mo*  
 17. INFORMANT (ADDRESS) *Chas Deekard St James Mo*  
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Thunora Mo* DATE *1-8-39*  
 19. FUNERAL DIRECTOR (ADDRESS) *W E Kiehlner St James Mo*  
 20. FILED *1-8-39* *Elmer B. Houck* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1-7-39*  
 22. I HEREBY CERTIFY, That I attended deceased from *Jan 1 1939*, to *Jan 7 1939*  
 last saw him alive on *Jan 7 1939*. Death is said to have occurred on the date stated above, at *4:45 a.m.*  
 The principal cause of death and related causes of importance were as follows:  
*Traumatic Pneumonia* Date of onset *1-6-39*  
*210 m*  
 Other contributory causes of importance:  
*Fracture of lung from fruit of Rib in ph. side (Chas's Rib joints acc'd)* *1-1-39*  
 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? *beat* Date of injury *1-1-39*  
 Where did injury occur? *near Nashville Mo*  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. *Public Highway #66*  
 Manner of injury *auto left highway & turned over*  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? *No*  
 If so, specify \_\_\_\_\_  
 (Signed) *Walter W. Green* M.D.  
 (Address) *St James Mo*

WRITE 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.

I X12004

STATEMENT BY LICENSED EMBALMER

I, W. E. Licklider, Licensed Embalmer No. 1970

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

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....  
working under my personal supervision.

Signed W. E. Licklider  
Licensed Embalmer No. 1970

**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.)**