

REC'D FEB 11 1939

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

4152
Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. 865
(b) Township Cass Primary Registration District No. 6143
(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 69 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME N. B. White

(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 (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 10 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
71 2 2

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

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) Nov. 1927 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Va.13. NAME J M White14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.15. MAIDEN NAME Louise White16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Va.

17. INFORMANT Joel Brooks
(ADDRESS) Cabool Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Miller Cemetery DATE Jan 15 39

19. FUNERAL DIRECTOR (NAME) Gaylord V Elliott
(ADDRESS) Cabool Mo.

20. FILED 1-15-39 Richard
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 12 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan-5, 1939 to Jan-11, 1939
I last saw him alive on Jan 11, 1939 Death is said to have occurred on the date stated above, at 3:40 PM

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

Cirrhosis of Stomach Date of onset _____

Other contributory causes of importance:

Coronary Occlusion

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) J. H. [Signature] M. D.(Address) Cabool Mo.

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. 9252

P. O. Address Abbeville, S.C.

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.

to that it may be... State, ...
... of such an embalmer. ...

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Texas Registration District No. 865-
(b) Township Cass Primary Registration District No. 6143
(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

Napoleon Bonaparte White
(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed

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.
71 2 2

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 1-15th 1929 R. P. Hubbard 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 him _____ 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 E. P. Fairchild, M. D.
(Signed) _____

(Address) Cabot mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary and important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. AGENT should be stated EXACTLY. AGENT should be stated EXACTLY. AGENT should be stated EXACTLY.

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