

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.

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

6933  
 Do not use this space.

REC'D MAR 16 1939

**1. PLACE OF DEATH**

(a) County Johnson Registration District No. 427  
 (b) Township Madison Primary Registration District No. 4253 Registered No. 7  
 (c) City Holden (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
 (e) Length of residence in city or town where death occurred 32 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)  
625 Cornelius Persinger

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Martha Persinger (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 18 - 1855

7. AGE YEARS 84 MONTHS \_\_\_\_\_ DAYS 6 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

FATHER 13. NAME Unknown

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Mrs Virginia Bowers Holden Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Farview Cemetery DATE Feb 27 1939

19. FUNERAL DIRECTOR (ADDRESS) T. W. Goodman Holden Missouri

20. FILED Feb 26 1939 Mrs G. H. Redford Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 24 1939

22. I HEREBY CERTIFY, That I attended deceased from June 1938, 1938, to Feb, 1939. I last saw him alive on Feb 23, 1939. Death is said to have occurred on the date stated above, at 7:30 A. M.

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

Cerebral Hemorrhage  
Myocarditis  
Carcinoma left Eye  
 Date of onset 2/24/39  
53'

Other contributory causes of importance:  
Myocarditis  
Carcinoma left Eye

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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) Kelly Rawlins / \_\_\_\_\_, M. D.  
 (Address) Holden Mo.

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 3/11/39

STATEMENT BY LICENSED EMBALMER

I, Samuel B Ropp, Licensed Embalmer No. 4044

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Samuel B Ropp

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

No. .... or by ..... Registered Apprentice No. ....

working under my personal supervision.

Signed Samuel B Ropp

Licensed Embalmer No. 4044

**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.)**