

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

10642  
Do not use this space.

REC'D APR 7 1939

1. PLACE OF DEATH

(a) County Dallas Registration District No. 243  
 (b) Township Shelton Primary Registration District No. 51337 Registered No. \_\_\_\_\_  
 (c) City Houston (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(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) unmarried  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. H. Johnson  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 25, 1870  
 7. AGE YEARS 67 MONTHS 11 DAYS 12 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper  
 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 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-18-1939  
 22. I HEREBY CERTIFY, that I attended deceased from March 15-1939 to March 18-1939. I last saw her alive on March 15-1939. Death is said to have occurred on the date stated above, at 10 a.m.

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

cerebral hemorrhage  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: 8261

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? no Date of injury 3-18-39  
 Where did injury occur? at home (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) C. G. Kessler, M. D.  
220 (Address) Arkland, Miss.

12. BIRTHPLACE (CITY OR TOWN) Dallas Co. (STATE OR COUNTRY) Mo.

FATHER 13. NAME Simon Decker  
 14. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Louisia Mallard  
 16. BIRTHPLACE (CITY OR TOWN) Tenn. (STATE OR COUNTRY)

17. INFORMANT Celand Johnson (ADDRESS) Houston Tex

18. BURIAL, CREMATION, OR REMOVAL PLACE Mallard Co. DATE 3-19-39

19. FUNERAL DIRECTOR (NAME) S. B. Jones (ADDRESS) Buffalo Mo

20. FILED 3-29-39 Mrs J. N. Shewmaker Local Registrar.

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**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.**