

DEC'D MAY 10 1939

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

14029  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Kear Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. Murphy Children Hospital Registered No. 1783  
 (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. da (f) How long in U. S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

(a) Residence, No. 625 Emory Jarmon St.  (If nonresident, give city or town and State)  
Concordia, Mo.  
 (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 Single  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 23, 1925  
 7. AGE YEARS 13 MONTHS 4 DAYS 4 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 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. School Boy  
 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) Detroit Mich.

FATHER 13. NAME Emory O. Jarmon  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME John Barker  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo.

17. INFORMANT (ADDRESS) John Turner Concordia, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Home April 29, 1939

19. FUNERAL DIRECTOR (ADDRESS) Cato & Speck Funeral Home Independence, Mo.

20. FILED Apr 28 1939 M. M. Crowe Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-27 1939

22. I HEREBY CERTIFY, That I attended deceased from April 27, 1939 to April 27, 1939, 19.....  
 I last saw him..... alive on....., 19..... Death is said to have occurred on the date stated above, at 12:40 P.M.  
 The principal cause of death and related causes of importance were as follows:

Osteomyelitis  
Septic Eru  
 Date of onset

Other contributory causes of importance:

Terminal Bronch  
Pneumonia  
 Name of operation..... Date of.....  
 What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

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) J. H. Crowe, M. D.  
 (Address) Concordia, Mo.

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**STATEMENT BY LICENSED EMBALMER**

I, Roland R. Speaks....., Licensed Embalmer No. 3604

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 Roland R. Speaks

Licensed Embalmer No. 3604

**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.)**

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF PUBLIC HEALTH  
EMBALMERS  
V. C. H. EAST

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

14029  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City..... (d) Street No. *Sherry Steps* 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.

Registered No. *1783*

2. PRINT FULL NAME *Emily Larcom*

(a) Residence, No. .... St.  *Concordia Mo*  
(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 *Male* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widow*

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.  
*13*

OCCUPATION 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED *4/28 1939*

*L. J. Combs*  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Apr. 27, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Dr. [Signature]*, to .....

I last saw *Dr. [Signature]* 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:

*Osteomyelitis of leg  
Secondary  
(non-tubercular)  
Suppuration*

Date of onset

Other contributory causes of importance:

*Broncho Pneumonia*

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 *L. J. Combs*, M. D.

(Signed) *L. J. Combs*, M. D.  
(Address) .....

SUPPLEMENTARY

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

