

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

15025  
Do not use this space.

1. PLACE OF DEATH **MAY 19 1939**

(a) County Worth Registration District No. 386  
 (b) Township Worth Primary Registration District No. 5598 Registered No. 22  
 (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 Jaylard Deboard  
 (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 w. 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) Mar. 17, 1935  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
4 1 15  
 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. Child  
 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) Hocoma, Mo

FATHER 13. NAME Ora Deboard C  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. C

MOTHER 15. MAIDEN NAME Susie B. Haney C  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Ora Deboard  
 (ADDRESS) Hocoma, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Big Springs DATE 5/31 1939

19. FUNERAL DIRECTOR (NAME) Farmis Funeral Home  
 (ADDRESS) Farmisville, Mo.

20. FILED 5/3 1939 Farmis B. Black  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 2, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Apr 30 1939, to May 2 1939  
 I last saw him live on Apr 30 1939. Death is said to have occurred on the date stated above, at 4 P. m.  
 The principal cause of death and related causes of importance were as follows:  
Bronchial Pneumonia Date of onset 4-29

Other contributory causes of importance:  
Had been an invalid all his life

Name of operation none 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 \_\_\_\_\_  
 (Signed) C. A. Beach, M. D.  
O. L. Black 346 (Address)

WITH UNFADING INK... THIS...  
 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.

1672

**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.**

STATEMENT OF THE EMBALMER  
BY THE EMBALMER  
STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

15-025-  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Howell Registration District No. 386  
 (b) Township Benton Primary Registration District No. 52-38  
 (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 Jayland Deboard  
 (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 s  
 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.  
4 1 15  
 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 19..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 2 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....  
 I last saw h. .... 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:  
Bronchial pneumonia Date of onset  
just a little making  
her mind, never even  
eat alone, weighed only 10 lbs.  
 Other contributory causes of importance:  
Had been an invalid all  
her life, no contraindications, 10 yrs  
 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 O. H. Beach, M. D.  
 (Signed) Elyah M.D.  
 (Address) no.

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXPLICITLY. PHYSICIANS should state CAUSE 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.

