

REC'D MAY 22 1939

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

15862

Do not use this space.

1. PLACE OF DEATH

(a) County Plumas
(b) Township Union
(c) CityRegistration District No. 711
Primary Registration District No. 5940Registered No. 60(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

(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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)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.

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
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

13. NAME

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

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19. FUNERAL DIRECTOR (NAME)
(ADDRESS)

20. FILED

5/19

1939

A. S. Lick

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/18, 193922. I HEREBY CERTIFY, That I attended deceased from
Oct 20, 1927, to Apr 18, 1939I last saw him alive on Jan 14, 1939. Death is said
to have occurred on the date stated above, at 6 P. m. —
The principal cause of death and related causes of importance were as follows:Cancer of hand Date of onset
1937

Other contributory causes of importance:

Amnesia 1-14-39Name of operation none Date of 2What test confirmed diagnosis? None Was there an autopsy? Yes23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? 0 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 0

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) C. M. Little, M. D.(Address) Crocker, 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. _____

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.