

1939 JUN 8 12

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

17667
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Boyer Primary Registration District No. 10.2 Registered No. 2069
 (c) City Boyer Mo (d) Street No. 19 E Sun Street 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. 1320 Central 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 (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lucius Mc Kee
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 12 1877
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 11 6
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) 5-18-39
 22. I HEREBY CERTIFY, That I attended deceased from 5-15-39, 1939, to 5-18-39, 1939.
 I last saw her alive on 5-18-39, 1939. Death is said to have occurred on the date stated above, at 7:30 am.
 The principal cause of death and related causes of importance were as follows:

Bronchopneumonia
 Date of onset 10/2
 Other contributory causes of importance:

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

Boyer Mo

FATHER

13. NAME James White

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

MOTHER

15. MAIDEN NAME Unkenston

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boyer Mo

17. INFORMANT (ADDRESS)

Record Clerk 19 E Sun Street

18. BURIAL, CREMATION, OR REMOVAL PLACE

Forest Hill DATE 5-20 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

W. F. Mayberry City

20. FILED

May 18 1939 M. M. Kerome Local Registrar.

Name of operation Date of
 What test confirmed diagnosis? 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) P. J. De Manna M. D.
 (Address) 19 E Sun Street

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.

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.