

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

19253
Do not use this space.

DEC'D JUN 13 1939

1. PLACE OF DEATH

(a) County Missouri Registration District No. 5-66
 (b) Township Tyravault Primary Registration District No. 5762
 (c) City Charleston (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.

Registered No. 47

2. PRINT FULL NAME

362 PLES-5 STARKS
 (a) Residence, No. R#3 Box 234 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 Color 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 7, 1884
 7. AGE YEARS 54 MONTHS 3 DAYS 29 If LESS than 1 day, hrs. or min.

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. Farmer
 10. Date deceased last worked at this occupation (month and year) Mar 25, 1939 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cossesko, Miss

13. NAME Joe Starks

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

15. MAIDEN NAME Flatterson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

17. INFORMANT (ADDRESS) Ed Starks, Charleston R#3 Box 234

18. BURIAL, CREMATION, OR REMOVAL PLACE Charleston Mo 5/8 1939

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

20. FILED 5-9-1939 F. D. Vernon Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/6 1939

22. I HEREBY CERTIFY, That I attended deceased from 5/1 1939 to 5/6 1939

I last saw him alive on 5/5 1939. Death is said to have occurred on the date stated above, at 4:55 p.m.
 The principal cause of death and related causes of importance were as follows:

Galbladder Encephalitis D.K.
 Other contributory causes of importance: none
 Name of operation none Date of _____
 What test confirmed diagnosis? Cl. Hyposp where an autopsy? no

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? no
 If so, specify _____

(Signed) L. Chas. Luning, M. D.
 (Address) Charleston Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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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, E. C. Nunnlee #4068,
Licensed Embalmer, by John F. Nunnlee Jr,
Registered Apprentice No. 3808, working under my personal supervision.

Signed E. C. Nunnlee

Licensed Embalmer No. 4068

P. O. Address Blodgett, Mo.

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.