

REC'D JUN 14 1939

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

20012  
Do not use this space.

1. PLACE OF DEATH *Texas*

(a) County *Texas* Registration District No. *1143*

(b) Township *1* Primary Registration District No. *4141*

(c) City *Spartan Mo.* (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_

(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 *Donald Paul Church*

(a) Residence, No. \_\_\_\_\_ St.  (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 *Child*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 18-38*

7. AGE YEARS MONTHS DAYS 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.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ time (years) \_\_\_\_\_ in this occupation

11. \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Texas Co. Mo.*

13. NAME *Paul Church*

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

15. MAIDEN NAME *Sylvia Knevel*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

17. INFORMANT (ADDRESS) *Paul Church*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Wyle Church* DATE *May 20, 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *None*

20. FILED *May 20, 1939* *Wm. S. M. Wilkitt* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 20, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *5/16/39*, 1939, to *5/19/39*, 1939

I last saw him alive on *5/19/39*, 1939. Death is said to have occurred on the date stated above, at *2:00 A.M.*

The principal cause of death and related causes of importance were as follows:

*Bronch. Pneumonia*

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

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 \_\_\_\_\_ (Signed) *J. J. McDaniel*, M. D.

(Address) *Sumnerville, Mo.*

WRITE PLAINLY, WITH UNFADING INK---THIS CARD IS INTENDED TO BE PRESERVED FOR BUREAU 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.

1072

**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.**

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH SERVICES  
EMBALMERS  
1968

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

20012  
Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. 1143  
 (b) Township Ozark Primary Registration District No. 6141 Registered No. ....  
 (c) City ..... (d) Street No. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. ....  
 (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 David Paul Church

(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 (write the word) Child

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.  
11 2

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.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19.....

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-20-1939

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:

Broncho Pneumonia  
1070  
 Date of onset  
 Other contributory causes of importance:  
Old cold

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 (Signed) D. Mc Daniels, M. D.  
 (Address) Summersville Mo

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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.

