

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.

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

27031

Do not use this space.

REC'D AUG 19 1939

1. PLACE OF DEATH

(a) County Stone Registration District No. 842
 (b) Township Pierson Primary Registration District No. 6104
 (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 7 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
69 3 8

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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) Ala.

FATHER 13. NAME Jim Barnes

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

MOTHER 15. MAIDEN NAME Mary Keaton

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Almon Williams
Cane mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE OSA DATE 7/15 1939

19. FUNERAL DIRECTOR (NAME) Cane + Son
 (ADDRESS) Cane mo

20. FILED 7-30 1939 Mrs Ethel Boyett
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/15 193922. I HEREBY CERTIFY, That I attended deceased from July 1 1939 to July 14 1939

I last saw him alive on July 8 1939. Death is said to have occurred on the date stated above, at 2:20 a.m.

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

Carcinoma of Prostate with invasion into rectum Date of onset ?

Other contributory causes of importance: 51

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? _____

Yes, specify _____

(Signed) A. P. Boyd, M. D.(Address) Cane mo

RECEIVED

District Health Officer No. 6,

District File Number 839-1666

Date Filed AUG 10 1955

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.