

REC'D SEP 14 1939

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

28500
Do not use this space.

1. PLACE OF DEATH *Barry* Registration District No. *29*
 (a) County *Flat Creek* Primary Registration District No. *5038* Registered No. *28*
 (b) Township *Flat Creek*
 (c) City *Cassville, Mo.* (d) Street No. *C. F. D. Cassville, Mo.* 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 *14* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME *William John Henry*
 (a) Residence, No. *Barry County* 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 *White* 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) *Sept. 5 1873*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 11 2
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) *7/20/39*
11. Total time (years) spent in this occupation *14*
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Sligo, Ireland*
13. NAME *William Henry*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Sligo, Ireland*
15. MAIDEN NAME *Jane Nixon*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Leitrim, Ireland*
17. INFORMANT (ADDRESS) *Allen Henry, Cassville, Mo.*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Horner* DATE *8/8/39*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Loon Funerall Home, Cassville, Mo.*
20. FILED *8-18 1939* *Superior* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug. 7 1939*
22. I HEREBY CERTIFY, That I attended deceased from *Aug 2 1939* to *Aug 6 1939*.
 I last saw *him* alive on *Aug. 6 1939*. Death is said to have occurred on the date stated above, at *12:30 a.m.*
 The principal cause of death and related causes of importance were as follows:
Intestinal Obstruction 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 *Stenn A. Salzer*, M. D.
 (Signed) *Stenn A. Salzer*
 (Address) *Cassville, 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.

FORM-1-13-39

1278

RECEIVED

District Health Officer No: 6,

District File Number 939-1863

Date Filed SEP 11 1939

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,

Rufus J. Miller

or by

Registered Apprentice No. _____ working under my personal supervision.

Signed

Rufus J. Miller

Licensed Embalmer No. 3794

P. O. Address Cassville, 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.

RECEIVED SEP 11 1939

MISSOURI DEPARTMENT OF HEALTH

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28500
Do not use this space.

1. PLACE OF DEATH

(a) County Barry Registration District No. 29
 (b) Township Flat Creek Primary Registration District No. 3038 Registered No. 28
 (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William John Henry

(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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 11 2

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)

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____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-7-39

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the day stated above, at _____ m.

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

Intestinal Obstruction
no malignancy
intussusception

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there 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? _____

If so, specify _____

(Signed) Wm W Salinger, M. D.

(Address) Cassville Mo

1 X12241
 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. If death occurred in a hospital or institution, 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.

SUPPLEMENT

