

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

30324
 Do not use this space.

REC'D SEP 15 1939

1. PLACE OF DEATH

(a) County Saline Registration District No. 797
 (b) Township Miami Primary Registration District No. 6040 Registered No. 7
 (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 George Samuel Page

(a) Residence, No. RD #2 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) ////// Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Sally Page
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) September-28-1888
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 55 10 22
 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. Farmer
 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) August-20-39
 22. I HEREBY CERTIFY, That I attended deceased from July 6 1939 to Aug. 20 1939
 last saw him alive on Aug. 20 1939. Death is said to have occurred on the date stated above, at 11 PM
 The principal cause of death and related causes of importance were as follows:

Chronic Nephritis Date of onset _____
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 Other contributory causes of importance:
Uremia - Convulsions

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline Couty Mo

FATHER 13. NAME Willford H Page

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fayette, Howard Co Mo.

MOTHER 15. MAIDEN NAME Don't Know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

17. INFORMANT (ADDRESS) Robert Page Slater Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE August 22 39 DATE Slater City

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jones & Salzer Slater Mo.

20. FILED 7-22 1939 Mrs. Audrey Haynes Logi Registrar

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 Car accident (Signed) _____, M. D.
 (Address) Slater Mo.

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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RECEIVED
District Health Officer No. 8,
District File Number 9/14/39
Date Filed

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.