

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31985

Registration District No. 19 245

Primary Registration District No. 5134C

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Butler 2
(b) City or town Rural - Ash Hill Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

8. (a) PRINT FULL NAME George Waters 362

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 19 1869
(Month) (Day) (Year)

8. AGE: Years 70+ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Madison Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Common laborer

11. Industry or business _____

12. Name Marion Waters

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name N. E.

15. Birthplace Mo. Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Waters

(b) Address Fisk Tp

17. (a) Burial (b) Date thereof Oct 8 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nale Cem.

18. (a) Signature of funeral director H. P. Phelps

(b) Address Caplan Bluff Mo

19. (a) Oct 10 (b) My Adams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butler
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. P.O. Fisk
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8
year 1939 hour 5 minute 15 A. M.

21. I hereby certify that I attended the deceased from Oct 5 1939
_____ 19 _____ to Oct 8 19 39
that I last saw him alive on Oct 5
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Due to Sarcoma of liver about 2 yrs.

Due to _____
Other conditions 46
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations none
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature T. F. Tarpley (M. D. or other) 1939
Address Fisk Mo Date signed 1939

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

5021-25-17-39
REV. 5-17-39
1 x1031

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.