

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.

DEPARTMENT OF HEALTH
 BUFFALO, N. Y. 1939

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 32264

Registration District No. 241 Primary Registration District No. 5334 Registrar's No. 1219

1. PLACE OF DEATH: 2
 (a) County Dallas
 (b) City or town Rural n. Benton
 (c) Name of hospital or institution:
 (If outside city or town limits, write "RURAL" and name of township)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days 6-20

3. (a) PRINT FULL NAME ALFRED JOHN BIRKEY JR.
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 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 9 10 1939
 (Month) (Day) (Year)

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

9. Birthplace Dallas Co mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name A. J. Birkey 0
 13. Birthplace neb. 1
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Bernice Boyd
 15. Birthplace neb.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. J. Birkey
 (b) Address Buffalo mo.

17. (a) Burial (b) Date thereof 9-10-1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation hindley

18. (a) Signature of funeral director H. B. Jones
 (b) Address Buffalo Mo.

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State mo (b) County Dallas
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9th day 10th
 year 1939 hour 7 minute A M.

21. I hereby certify that I attended the deceased from 9-10, 1939, to 9-10, 1939;
 that I last saw h _____ alive on _____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
 Due to Unknown
was stillborn
 Due to _____

Other conditions _____ (include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

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)
 (a) Means of injury _____

23. Signature D. H. Greenwald (M. D. or other) _____
 Address Buffalo Mo. Date signed _____

RECEIVED

District Health Officer No. 7;

District File Number 10-39-1871

Date Filed 10-13-39

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32264
Do not use this space.

1. PLACE OF DEATH
 (a) County Dallas Registration District No. 241
 (b) Township W. Benton Primary Registration District No. 3334
 (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 Alfred John Birkley Jr
 (a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-10-1939

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
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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) Dallas to mother

FATHER
 13. NAME A. J. Birkley
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tex

MOTHER
 15. MAIDEN NAME Bernice Boyd
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) neb

17. INFORMANT (ADDRESS) A. J. Birkley
 18. BURIAL, CREMATION, OR REMOVAL PLACE Landley DATE 9-10-39
 19. FUNERAL DIRECTOR (ADDRESS) L. B. Jones
 20. FILED 9/22 1939 Harvey Morn Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-10-1939

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said to have occurred on the date stated above, at 7A m. The principal cause of death and related causes of importance were as follows:
unknown - Stillborn
 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 V. H. Greenwood, M. D.
 (Signed) Buffalo
 (Address) Buffalo

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MISSOURI STATE BOARD OF HEALTH

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