

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

32780
Do not use this space.

53
1. PLACE OF DEATH ²
(a) County Racine Registration District No. 952
(b) Township Franklin Primary Registration District No. 5617 Registered No. _____
(c) City Orea (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 Bill Larned unnamed
(a) Residence, No. 300 Orea Mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>8-29-1909</u>		
7. AGE	YEARS	MONTHS
	0	0
		DAYS
		0
OCCUPATION	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) <u>Orea Mo</u>		
FATHER	13. NAME <u>Halden A Mott</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Wright Co Mo</u>	
MOTHER	15. MAIDEN NAME <u>Ernest Ruth Esther</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Racine Mo</u>	
17. INFORMANT (ADDRESS) <u>H A Mott</u>		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE _____ DATE _____ 19__		
19. FUNERAL DIRECTOR (ADDRESS) _____		
20. FILED <u>Sept. 12, 1939 Mrs. Vida Lambeth</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-29-1939

22. I HEREBY CERTIFY, That I attended deceased from delivered deceased 19__
still born
I last saw h. _____ alive on _____, 19__ Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
unknown
still born

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 _____
(Signed) J. W. Lindsey M. D.
Carway M (Address) _____

Date of onset _____

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

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.)