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.

I X16605

NOV 18 1939

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

35812
Do not use this space.

1. PLACE OF DEATH
(a) County Clark — Registration District No. 189
(b) Township [illegible] — Primary Registration District No. 5263 — Registered No.
(c) or City Alexandria — (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 John Riley White
(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): Nov. 2, 1858
7. AGE: Years 80 — Months 11 — Days 27 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: At Home
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): Iowa

FATHER
13. NAME: William White
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

MOTHER
15. MAIDEN NAME: Nancy Rath
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): not Known

17. INFORMANT (ADDRESS): Mrs Thomas Wooden, Kahoka Mo.
18. BURIAL, CREMATION, OR REMOVAL — PLACE: Ashton Cem. DATE: Oct 31, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Fred J Karle, Kahoka Mo.
20. FILED: Nov 10, 1939 — Dr F A S Rebo, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Oct 29, 1939
22. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1939, to Oct 28, 1939
I last saw him alive on Oct 28, 1939. Death is said to have occurred on the date stated above, at 9 AM
The principal cause of death and related causes of importance were as follows:

	Date of onset
death followed prostate gland operation ✓ Uremic Poisoning	

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) F A S Rebo, M. D.
173 (Address) Alexandria Mo

(Licensed Embalmer's Statement on Reverse Side)

137

RECEIVED
District Health Officer No. 10
District File Number 11-39-1999
Date Filed NOV 15 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, or by ....., Registered Apprentice No. ....., working under my personal supervision.

Signed F. J. Karle

Licensed Embalmer No. 1023

P. O. Address Kahoka 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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

35812 7
Do not use this space.

1. PLACE OF DEATH
(a) County Clark — Registration District No. 189
(b) Township Vernon — Primary Registration District No. 5263 — Registered No.
(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 John Riley White
(a) Residence, No. — St.
(Usual place of abode, if no street address, write county or city) (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 (write the word): S
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE — YEARS: 80 — MONTHS: 11 — DAYS: 29 — If LESS than 1 day, ...hrs. or ....min.

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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
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) Oct 29 1939

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

	Date of onset
Death followed pro-state gland operation	
Uremia Poisoning	51

Other contributory causes of importance:
Malignancy or senile debility been sick for over 15 yrs

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) F. A. S. Revo, M. D.
(Address) Alexandria Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.