

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

36487

Do not use this space.

1. PLACE OF DEATH  
 (a) County LACLEDE Registration District No. 449  
 (b) Township OSAGE Primary Registration District No. 5618  
 (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 SAO John Franklin White  
 (a) Residence, No. Rt. Lebanon Mo 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)  
WIDOWER

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY 9-1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
84 4 21

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.  
 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)  
AYRON W. VA.

13. NAME ROBT. WHITE

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
IRELAND

15. MAIDEN NAME RUTH WADE

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
IRELAND

17. INFORMANT (ADDRESS)  
M. W. WHITE  
CORRECTIONVILLE LOW

18. BURIAL, CREMATION, OR REMOVAL PLACE HONSINGER CEM. DATE SEPT. 4, 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS)  
Palmer  
Lebanon Mo

20. FILED 10-5-39 J. A. McCaleb  
 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) OCT. SEPT 3, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept. 30th, 1939, to October 3rd, 1939.  
 I last saw him alive on Sept 30th, 1939. Death is said to have occurred on the date stated above, at 4 A. m.  
 The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage

Date of onset  
Sept. 30, 39

Other contributory causes of importance:  
g. f. w.

Name of operation none Date of                     

What test confirmed diagnosis? Physical exam Was there an autopsy? no

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 none

Nature of injury                     

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify (Signed)                     , M. D.

(Address) Lebanon Mo

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.

RECEIVED

District Health Officer No. 7,

District File Number 7-29-15

Date Filed 11-10-39

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**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

36487  
Do not use this space.

1. PLACE OF DEATH

(a) County Coledale Registration District No. 449  
 (b) Township Orange Primary Registration District No. 3678 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 Franklin 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 (to fit the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 9 - 1854

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>85</u>	<u>8</u>	<u>4</u>	<u>24</u>	

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 12/13 1939 J. A. McComb Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct-3-1939

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:

Cerebral Hemorrhage 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 .....

(Signed) P. Thompson, M. D.

(Address) Lebanon Mo

SUPPLEMENTARY

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

