

REC'D DEC 13 1939

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

39157
Do not use this space.

1. PLACE OF DEATH

(a) County Butler Registration District No. 89
(b) Township St. Blasius Primary Registration District No. 5131
(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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

Registered No. 264

2. PRINT FULL NAME

(a) Residence, No. 340 Onda Medley St.
Wappapella Mo (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 Male 4. COLOR OR RACE White 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) June 19-1935

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
4 4 14

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) Wappapella Mo

FATHER 13. NAME George Medley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Deer cr Mo

MOTHER 15. MAIDEN NAME Emma Medley

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Deer cr Mo

17. INFORMANT (ADDRESS) Geo Medley
Wappapella Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Little Bud's life DATE Nov 2 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) N. F. Pheasant
Paplar Bldg

20. FILED 11/4/39 O. B. Stricker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 1 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1939, to October 29, 1939

I last saw him alive on October 29, 1939. Death is said to have occurred on the date stated above, at 3 P. m.

The principal cause of death and related causes of importance were as follows:

Coronary atherosclerosis

Date of onset 10-15-39

Other contributory causes of importance: Myocardial infarction 10-25-39

Name of operation Decomposition Date of 10-10-39

What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury 9-30, 1939

Where did injury occur? Mr. Shannon Co (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. Automobile wreck

Manner of injury _____ Nature of injury Fract. skull

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

(Signed) Wm. H. Harrison, M. D.
(Address) St. Joe, Butler Co Mo

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.

74

G. Hermsdorn

~~Hermsdorn~~

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

39157
Do not use this space.

1. PLACE OF DEATH

(a) County Butler Registration District No. 89
(b) Township Paplar Bluff Primary Registration District No. 2131 Registered No. 264
(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 Onda Medley

(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 s (Use the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 4 14

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) _____

13. NAME

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

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) Nov 1 1939

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

I last saw h. _____ alive on _____, 19__ Death is said to have occurred on the day stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Cerebral abscess
meningitis Cerebral
Date of onset _____
Other contributory causes of importance: 210111

Name of operation Decompressions 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 Accident Date of injury Oct 31 1939
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 Accidental with 2 cys. 7
Nature of injury Fractured s. skull frontal base

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____
(Signed) H. S. Henrichson, M. D.
(Address) Paplar Bluff Mo

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.

SUPPLEMENTARY

