

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
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.

DEC 18 1939
Registration District No. 431

Primary Registration District No. 3023

Registrar's No. 128

1. PLACE OF DEATH:

(a) County Tankson

(b) City or town Warrensburg

(c) Name of hospital or institution: Oak Hill Sanitarium
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 2 weeks 6 days
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Tankson

(c) City or town Warrensburg
(If outside city or town limits, write "RURAL")

(d) Street No. 701 S. Washington
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME Daniel W. Boyer

3. (b) If veteran, name war Civil War

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Nov. day 24
year 1939 hour 12 minute _____ A.M.

21. I hereby certify that I attended the deceased from 10-13-39
_____, 19____, to Nov-24, 19____;
that I last saw him alive on 11-24, 19____;
and that death occurred on the date and hour stated above.

4. Sex M. 5. Color or race Wk.

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Edwina P. Nash

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 6 1846
(Month) (Day) (Year)

Immediate cause of death Labor Pneumonia Duration 11-20-39

Due to 7 yellow fractured hip bone

Due to _____

Other conditions 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
(Include pregnancy within 3 months of death)

8. AGE: Years 93 Months 6 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace INDIANA
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

Major findings: none

Of operations none

Of autopsy none

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name Peter Boyer

13. Birthplace Maryland
(City, town, or county) (State or foreign country)

14. Maiden name Eliza Berkhizer

15. Birthplace Maryland
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 10-13-39

(c) Where did injury occur? Warrensburg (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

16. (a) Informant's own signature Mrs. A. B. Mc. Klotz

(b) Address 221 N. 24th St. Joseph Mo.

17. (a) Burial (b) Date thereof Nov. 26 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director W. H. Wilcox

(b) Address Warrensburg Mo. 3011

19. (a) Nov 26 (b) 39
(Date received local registrar) (Registrar's signature)

While at work? no (Specify type of place) (e) Means of injury fell on

23. Signature D. F. M. Klotz (M. D. or other) _____
Address Warrensburg Mo. Date signed 11-27

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 1/11/39

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. 3053

P. O. Address Warrensburg 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.