

DEC 15 1939

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

40072  
Do not use this space.

1. PLACE OF DEATH

(a) County LACLEDE 2 Registration District No. 449  
(b) Township LEBANON Primary Registration District No. 5609  
(c) City 1 (d) Street No. P. 2 LEBANON Mo 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

H. C. VALERA W. JELLEY  
(a) Residence, No. ROBT. 2, 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOW  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF J. F. JELLEY  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEPT. 2, 1939  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
49 2 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSE WIFE  
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) FALL CITY MO  
(STATE OR COUNTRY)

FATHER 13. NAME CHARLES METTZ

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

MOTHER 15. MAIDEN NAME MARY F GENTRY

16. BIRTHPLACE (CITY OR TOWN) MOODAWAY Co. Mo  
(STATE OR COUNTRY)

17. INFORMANT Frank Metzger  
(ADDRESS) Lebanon Mo

18. BURIAL, CREMATION, OR REMOVAL  
PLACE LEBANON DATE DEC 9 1939

19. FUNERAL DIRECTOR (NAME) PALMER'S  
(ADDRESS) LEBANON

20. FILED 12-1-39 J. A. M. Coomb  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) NOV 30 1939

22. I HEREBY CERTIFY, That I attended deceased from about Jan 1 1939 to Nov. 30 1939.  
I last saw h. alive on 11-30 1939. Death is said to have occurred on the date stated above, at 8:40 P.M.  
The principal cause of death and related causes of importance were as follows:

Sclerosis of post. Columnus  
Diagnosed as syphilitic  
Date of onset 1935

Other contributory causes of importance: 34

Name of operation Physician Date of no  
What test confirmed diagnosis Physician 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 \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify J. A. M. Coomb M. D.  
(Signed) 41/12 (Address) \_\_\_\_\_

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 2-37-1729  
Date Filed 12-13-37

**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 [Signature]  
Licensed Embalmer No. 1161  
P. O. Address [Signature]

**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

40072  
Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449  
 (b) Township Lebanon Primary Registration District No. 2609 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

Valera W. Jolley  
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 30 1939

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sep 2 1890

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hra. or .....min.  
49 2 28

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

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.....

Date of onset

12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

Other contributory causes of importance:

FATHER 13. NAME

Name of operation ..... Date of.....

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

What test confirmed diagnosis? ..... Was there an autopsy?.....

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....

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

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

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

Manner of injury ..... Nature of injury .....

19. FUNERAL DIRECTOR (ADDRESS)

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

20. FILED 116 1940 J. A. McComb Local Registrar

If so, specify..... (Signed) J. A. McComb M. D. (Address) Lebanon Mo

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

