

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

**40447**  
Do not use this space.

*Dr Cooper*  
**DEC 15 1939**

**1. PLACE OF DEATH**

(a) County Democrat Registration District No. 1  
 (b) Township 1 Primary Registration District No. 1 Registered No. \_\_\_\_\_  
 (c) City Halland (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**

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
M. R. Bailey

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 20 1860

7. AGE YEARS 79 MONTHS \_\_\_\_\_ DAYS 12 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) Ala

FATHER 13. NAME Unobtainable

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

MOTHER 15. MAIDEN NAME ✓

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

17. INFORMANT (ADDRESS) Mrs Ches. Jorner

18. BURIAL, CREMATION, OR REMOVAL PLACE Lester Cemetery DATE 11-2 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Boyd Funeral Home  
Blytheville Ark

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-1 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-22-1939 to 10-30-1939

I last saw h. alive on 10-30-1939. Death is said to have occurred on the date stated above, at 11:40 a.m.

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

Carcinoma of Prostate Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? exploratory 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? no

If so, specify \_\_\_\_\_  
 (Signed) L. E. Cooper, M. D.  
 (Address) Cooler 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.

RECEIVED

District Health Officer No. 3,

District File Number 1229-6

Date Filed 12/8/39

---

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.....

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

40447

Do not use this space.

1. PLACE OF DEATH *Remiseast*

(a) County *Holland* Registration District No. *656*

(b) Township *Holland* Primary Registration District No. *6281* Registered No. \_\_\_\_\_

(c) City *Holland* (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_

(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 *General M. Bailey*

(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 *m* (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 20 1860*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<i>79</i>	<i>-</i>	<i>12</i>	

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 \_\_\_\_\_

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *11-1* 19*39*

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:

*Carcinoma of prostate*

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

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

FATHER

13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) *Mrs. E. J. Jones*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Lester Cemetery 11-2* 19*39*

19. FUNERAL DIRECTOR (ADDRESS) *Halt General Home*  
*Blytheville Ark*

20. FILED *1-31* 19*40* *Yombregance* Local Registrar.

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) *H. E. Cooper* M. D.  
(Address) *Coates*

SUPPLEMENTARY

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

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

