

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.

Registration District No. 486

Primary Registration District No. 5649

State File No. _____

Registrar's No. 41

1. PLACE OF DEATH:

(a) County Lincoln
 (b) City or town Rural - Hurricane
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)

In this community _____
 years, months or days

3. (a) PRINT FULL NAME Lauretta L. Berhart
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Aug 12, 1939
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>4</u>	<u>17</u>	hr. _____ min. _____

9. Birthplace Lincoln Co Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name John F. Berhart
 13. Birthplace Osage Co Mo
 (City, town, or county) (State or foreign country)

14. Maiden name Ruth Warden
 15. Birthplace Mills Co Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John F. Berhart
 (b) Address Elshury Mo

17. (a) Burial (b) Date thereof Jan 1 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Belle Mo

18. (a) Signature of funeral director W. B. Bradley
 (b) Address Elshury Mo

19. (a) Dec. 30 (b) Eta Powell
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20
 year 1939 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from Dec 27
 _____, 1939, to Dec 19, 1939;
 that I last saw him alive on Dec 29, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
 Duration 2 days

Due to Hypox respiratory infection

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature J. C. H. Hootley (M. D. or other) M.D.
 Address Elshury Mo Date signed Dec 30

PHYSICIAN
 Underline the cause to which death should be charged statistically

109R

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

43894

Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 486
(b) Township Jurricane Primary Registration District No. 3649
(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

Lanetta L. Berhorst
(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 29 1939

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

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

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

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, _____ hrs. or _____ min.
4 17

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 _____

Pneumonia, Bronchial Date of onset _____
Strep Respiratory in-
fection Common Cold

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

Other contributory causes of importance:
1072

13. NAME

Name of operation _____ Date of _____

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

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

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____

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

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury _____
Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19____

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

19. FUNERAL DIRECTOR (ADDRESS)

(Signed) H. C. Huntley, M. D.
(Address) Elberly mo

20. FILED _____, 19____ Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.

SUPPLEMENT

