

FILED NOV 9 1984

CERTIFICATE OF DEATH

DELAYED

235065

124 39-045015

DO NOT WRITE
ON THIS STUBREGISTRATION DISTRICT NO. 314PRIMARY REGISTRATION DISTRICT NO. 6064REGISTRAR'S NO. 9999

2
4
5A (Type of death)
7B
7C
8
10
12
14A
15A
15B
15C & E
15D
21A
24A
25
26
26
26
26
27
29A-F
29G-ST
29G-CO
29G-CY

VS 300
Rev. 1/78

IF DEATH OCCURRED IN INSTITUTION, SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

DECEASED

PARENTS

DISPOSITION

CERTIFIER

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE
STATING THE UNDERLYING CAUSE LAST

CAUSE OF DEATH

TYPE OR PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

Filed on the basis of a notarized affidavit signed by Vivian and Walter Birdwell on Oct. 16, 1984. And an obituary from the Lowery City Independent newspaper dated Aug. 24, 1939.

DECEASED-NAME	FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (Mo., Day, Yr.)
1. Joseph	Jackson	White	2. Male	3. Aug. 20, 1939	
RACE—(e.g., White, Black, American Indian, etc.) (Specify)	AGE—Last Birthday (Yrs.)	UNDER 1 YEAR	UNDER 1 DAY	DATE OF BIRTH (Mo., Day, Yr.)	COUNTY OF DEATH
4. White	5a. 77	MOS. 5b.	DAYS 5c.	MINS. 5d.	6. Dec. 1, 1862
7a. St. Clair	7b. Rural- St. Clair Co.				
CITY, TOWN OR LOCATION OF DEATH			HOSPITAL OR OTHER INSTITUTION—Name (If not in either, give street and number)		
7c. Rural (near Bear Creek Church)					
STATE OF BIRTH (If not in U.S.A., name country)	CITIZEN OF WHAT COUNTRY	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	SURVIVING SPOUSE (If wife, give maiden name)		WAS DECEASED EVER IN U.S. ARMED FORCES?
8. Missouri	9. U. S. A.	10. Widowed	11.		12. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
SOCIAL SECURITY NUMBER		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY	
13.		14a. Farmer		14b. Farming	
RESIDENCE-STATE	COUNTY	CITY, TOWN OR LOCATION AND ZIP CODE		STREET AND NUMBER	INSIDE CITY LIMITS (Specify Yes or No)
15a. Missouri	15b. St. Clair	15c. Rural Osceola		15d.	15e. No
FATHER-NAME	FIRST	MIDDLE	LAST	MOTHER-MAIDEN NAME	FIRST
16. James	Harvey	White	17. Cynthia	Ann	Johnston
INFORMANT-NAME (Type or Print)			MAILING ADDRESS	STREET OR R.F.D. NO.	CITY OR TOWN
18a. Thomas J. White			18b. 7134 N. 68th Drive		18c. Glendale, Arizona
BURIAL, CREMATION, REMOVAL, OTHER (Specify) DATE			CEMETERY OR CREMATORY-NAME	LOCATION	CITY OR TOWN
19a. Burial Aug. 23, 1939			19b. Iconium Cemetery		19c. Iconium, Missouri
FUNERAL SERVICE LICENSEE Or Person Acting As Such (Signature) NUMBER			NAME OF FACILITY		ADDRESS OF FACILITY
20a. Mortuary			20b.		20c. Osceola, Missouri
REGISTRAR			DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)		
21a. (Signature) <i>Garland H. Lard</i>			21b. 11-9-84		
22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) <i>Garland H. Lard</i> DATE SIGNED (Mo., Day, Yr.)			23a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) <i>Garland H. Lard</i> DATE SIGNED (Mo., Day, Yr.)		
22b. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			23b. PRONOUNCED DEAD (Mo., Day, Yr.)		
22d. Dr. Ruth SeEVERS			23c. ON		
NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)			MO. LICENSE NO.		IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (Specify)
24a.			24b.		25.
26. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)					
PART I (a) Heart Attack					
DUE TO, OR AS A CONSEQUENCE OF:					
(b) DUE TO, OR AS A CONSEQUENCE OF:					
(c) DUE TO, OR AS A CONSEQUENCE OF:					
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)				AUTOPSY (Specify Yes or No)	
27.				28. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER (Specify Yes or No)	
ACC. SUICIDE, HOM. UNDET. OR PENDING INVEST. (Specify)	DATE OF INJURY (Mo., Day, Yr.)	HOUR OF INJURY	DESCRIBE HOW INJURY OCCURRED		
29a.	29b.	29c. M	29d.		
INJURY AT WORK (Specify Yes or No)		PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	LOCATION		STREET OR R.F.D. NO., CITY OR TOWN, COUNTY, STATE
29e.		29f.	29g.		IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS
29e.		29f.	29g.		30. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK

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 _____; Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.