

Registration District No. 266Primary Registration District No. 5370Registrar's No. 7

1. PLACE OF DEATH:

- (a) County Dent
(b) City or town Spring Creek Saline Rural
(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 40 (Specify whetherIn this community
years, months or days)8. (a) PRINT FULL NAME Charley Bock 2008. (b) If veteran,
name war _____8. (c) Social Security
No. _____4. Sex M. 5. Color or
race W.6. (a) Single, widowed, married,
divorced single

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

alive _____ years

7. Birth date of deceased March 1875
(Month) (Day) (Year)8. AGE: Years 64 Months 10 Days _____ If less than one day
hr. min.9. Birthplace Springfield Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Chas. Bock
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Glenn Bock
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Minnetta Bock(b) Address Saline Mo17. (a) Burial (b) Date thereof 1-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Cedar Grove18. (a) Signature of funeral director Robert H. Haulman(b) Address Saline Mo19. (a) Jan 27 1940 (b) J. E. Smith M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Dent
(c) City or town Rural Saline Spring Creek
(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 Jan day 26
year 1940 hour _____ minute 7 A. M.21. I hereby certify that I attended the deceased from Jan 26, 1940, to Jan 26, 1940
that I last saw him alive on Jan 25, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Pneumonia Duration
Lobar R + L 112 229Due to Influenza 2 weeksOther conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations ✓Of autopsy no

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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)
Means of injury _____23. Signature J. E. Smith (M. D. or other)Address Saline Mo Date signed 1-26-40

RECEIVED

District Health Officer No. 5,

District File Number 240 176

Date Filed 2740

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

H. D. Holman, Registered Apprentice No. _____
working under my personal supervision.

Signed

Licensed Embalmer No. 928

P. O. Address Palmer 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

2224

Do not use this space.

1. PLACE OF DEATH

(a) County Dent Registration District No. 266
(b) Township Spring Creek Primary Registration District No. 3270
(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

(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

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) mar 26 1876

7. AGE YEARS 64 MONTHS 10 DAYS If LESS than 1 day, ... hrs. or min.

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 21 19 to F. E. Butler, M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-26 19 40

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:

Date of onset

Other contributory causes of importance:

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) W. G. Dillon, M. D.

(Address) Salem, Mo.

