

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

2652
Do not use this space.

FILED FEB 15 1940

1. PLACE OF DEATH

(a) County Jasper Registration District No. 408
 (b) Township 0 Primary Registration District No. 3020 Registered No. 10
 (c) City Carthage (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 76 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 321 Orchid 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 15, 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 10 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
 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) St. Scott Kansas

FATHER 13. NAME John Landers

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

MOTHER 15. MAIDEN NAME Sarah

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

17. INFORMANT (ADDRESS) Arbro Shorn
Route 1 - Reeds, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Reeds Cemetery DATE Jan. 14 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kneel on entry
Carthage, Mo.

20. FILED Jan. 13, 1940 E. J. McIntire, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 13 1940

22. I HEREBY CERTIFY, that I attended deceased from Jan. 6 1940 to Jan. 13 1940
 I last saw h. or alive on Jan. 13 1940 Death is said to have occurred on the date stated above, at 1:50 P.M.
 The principal cause of death and related causes of importance were as follows:

Pneumonia, Hypostatic
terminal
 Date of onset 1-12-40
E. J. W.

Other contributory causes of importance:
Cerebral Hemorrhage
Arteriosclerosis
 Date 1-5-40

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical 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) Russell W. Harris, M. D.
 (Address) Carthage, 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. 6,

District File Number 240-478

Date Filed FEB 13 1940

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..... *Ernest R. Stuebel*

Licensed Embalmer No. 391

P. O. Address..... *Cartage*

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.