

Registration District No. 677

Primary Registration District No. 440.3

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Edgar
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McFarland Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Phelps
(c) City or town Edgar Springs
(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.

In this community _____
years, months or days)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13
year 1940 hour 9 minute 40 A.M.
21. I hereby certify that I attended the deceased from Jan 12
1940 to Jan 13 1940
that I last saw him alive on Jan 13 1940
and that death occurred on the date and hour stated above.
Immediate cause of death Sobar Pneumonia Duration _____

3. (a) PRINT FULL NAME Jacob Black 420

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex mm 5. Color or race wh 6. (a) Single, widowed, married, divorced mar

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

7. Birth date of deceased Aug 29 1861
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 14
If less than one day hr. _____ min. _____

9. Birthplace Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Minister - Farmer

MOTHER FATHER

11. Industry or business _____
12. Name John Black
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name Rebecca Taylor
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jacob Black
(b) Address Edgar Springs Mo

17. (a) Burial (b) Date received Jan 14 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Edgar Springs

18. (a) Signature of funeral director W. J. ...
(b) Address ...

19. (a) Jan 14 1940 (b) Jan 7 1940
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____

Other conditions (includes pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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) _____
(a) Means of injury _____
23. Signature W. J. ... (M. D. or other) _____
Address _____ Signed 1-14-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

RECEIVED

District Health Officer No. 5,

Signed

District File Number 240 232

Licensed Embalmer No.

Date Filed 2/6/40

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.