

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

4022

Registration District No. 842 Primary Registration District No. 610-4 45/12 Registrar's No. _____ State File No. _____

1. PLACE OF DEATH:
(a) County Stone
(b) City or town Craze - mo.
(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 _____)

3. (a) PRINT FULL NAME John Carnes 152
3. (b) If veteran, name war _____ 3. (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 Dec Unknown 1863
(Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Unknown

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Carnes
(b) Address Hamburg Ill.

17. (a) ~~1863~~ (b) Date thereof Dec 16-1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hamburg Ill

18. (a) Signature of funeral director George H. Mandan
(b) Address Craze

19. (a) Dec 15-1940 (b) Mrs Ethel Droggitt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State mo (b) County Stone
(c) City or town Craze
(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 13
year 1939 hour 11 minute 0, M.

21. I hereby certify that I attended the deceased from Jan 10-
1939, to Dec 13-, 1939.
that I last saw him alive on Dec 12-, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
Due to Hypertension
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
10 days
10 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings: Of operations None
Of autopsy None

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 H. L. Webb (M. D. or other) _____
Address Craze mo. Date signed 12-14-39

RECEIVED

District Health Officer No. 6,

District File Number 240-403

Date Filed FEB 12 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 George H. Manlove

Licensed Embalmer No. 3827

P. O. Address Crane 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.