

Registration District No. 1901940

Primary Registration District No. 5264

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Rural - Shenandoah
(If outside city or town limits, write "RURAL" and name of township)
(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 1 week (Specify whether years, months or days)

3. (a) PRINT FULL NAME Warren Arvine Decker

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Aug - 28 - 1938
(Month) (Day) (Year)

8. AGE: Years 1 Months 5 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Warren A. Decker
13. Birthplace Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Vernice Sipe
15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Warren A. Decker
(b) Address Medell Mo.

17. (a) removal (b) Date thereof Feb. 15 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairfield Ia.

18. (a) Signature of funeral director Otis L. Jettling
(b) Address Kahoka Mo.

19. (a) 2/15 1940 (b) J. Robinson 174
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clark
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Medell
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 15
year 40 hour 11 minute 25 M.

21. I hereby certify that I attended the deceased from 2 - 13, 1940, to 2 - 15, 1940, that I last saw him alive on 2 - 15, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: pneumonia
Aschoff's

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration

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) (e) Means of injury _____

23. Signature J. Robinson (M. D. or other) Dr.
Address Kahoka Date signed 2-15-40

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

107K

RECEIVED

District Health Officer No. 10

District File Number 3-40-687

Date Filed MAR 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.....

Feb. 15 - 1940, Registered Apprentice No.
working under my personal supervision.

Signed.....

Otis L. Lutting
Licensed Embalmer No. 2965

P. O. Address Luray 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6302**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **196**

Primary Registration District No. **3264**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Clark**
(b) City or town **Zimmerman T.P.**
(If outside city or town limits, write "RURAL" and name of township)
(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
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

3. (a) PRINT FULL NAME

Warren Arvine Decker

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 _____

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

7. Birth date of deceased (Month) (Day) (Year) _____

8. AGE: Years Months Days If less than one day
1 5 17 _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year) _____
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **11-4-1940** (b) **J.R. Bridges**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **2** day **15** year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho Pneumonia**
Due to **None**

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations **1074**

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) (e) Means of injury _____

23. Signature **S.H. Channing** (M. D. or other) _____

Address **Kahoka** Date signed _____

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

SUPPLEMENTAL

