

Registration District No. 896

Primary Registration District No. 6198

Registrar's No. 3

FILED MAR 1 1940

1. PLACE OF DEATH:

(a) County Webster
 (b) City or town rural - Ozark Township
(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 x (Specify whether years, months or days)
 In this community life

3. (a) PRINT FULL NAME John Allen Deckard 263

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

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

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

7. Birth date of deceased December 13, 1861
(Month) (Day) (Year)

8. AGE: Years 78 Months 10 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Webster County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER { 12. Name Sylvester Deckard

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Jim Deckard

(b) Address Marshfield, Missouri

17. (a) Burial (b) Date thereof Jan. 8, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Welch Cemetery

18. (a) Signature of funeral director Rev. Rainey

(b) Address Marshfield, Missouri

19. (a) 2-8-70 (b) E. C. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6
 year 1940 hour 11 minute _____ P. M.

21. I hereby certify that I attended the deceased from Jan. 3
January 3, 1940 to Jan. 6, 1940
 that I last saw him alive on Jan. 6, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage - 3 days

Due to Rupture in Cerebral Blood vessel

Due to Essential Hypertension _____ years

Other conditions Slight Stenosis - (Unable to swallow)

Major findings: No Hypostatic Pneumonia

Of autopsy No

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? _____

23. Signature C. P. Macdonald (M. D. or other) M.D.
 Address Marshfield Date signed 1/7/40

Duration
 3 days
 Years
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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.

RECEIVED

District Health Officer No. 6,

District File Number 340-834

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.....

.....
working under my personal supervision.

~~X~~....., Registered Apprentice No.....

Signed.....
~~X~~

Licensed Embalmer No.....

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.