

FILED MAR 14 1940

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

8556

Do not use this space.

1. PLACE OF DEATH

(a) County Worth Registration District No. 903
 (b) Township Blotchall Primary Registration District No. 4511 Registered No. _____
 (c) City Grant City, Mo. (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred 1 1/2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME NOBLE CORDIE EARLY

(a) Residence, No. _____ 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 <u>M</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Cora Early</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 3, 1864</u>		
7. AGE	YEARS <u>75</u>	MONTHS <u>4</u>
	DAYS <u>1</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Reduce paper</u>	11. Total time (years) spent in this occupation <u>35</u>
	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) <u>Summer of 1936</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Nebraska</u>		
FATHER	13. NAME <u>Dr. John Early</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana</u>	
MOTHER	15. MAIDEN NAME <u>Jane Mull</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana</u>	
17. INFORMANT (ADDRESS) <u>Blecher Early Grant City, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Grant City Cem.</u> DATE <u>2/16</u> 19 <u>40</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Josh C. Dumble Grant City, Mo.</u>		
20. FILED _____ 19 _____ Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-4 1940

22. I HEREBY CERTIFY, That I attended deceased from June 1938 to 2-4 1940
 I last saw him alive on 2-1 1940. Death is said to have occurred on the date stated above, at 5:50 P. m.
 The principal cause of death and related causes of importance were as follows:
No specific
intermittent
 Date of onset 1938

Other contributory causes of importance:
hypertension 171

Name of operation no Date of _____
 What test confirmed diagnosis? physical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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) J. H. H. M.D. M. D.
 (Address) Grant City, Mo.

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 Arch C. Temple

Licensed Embalmer No. 3252

P. O. Address Grant City, 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. **85376**

Registration District No. **903**

Primary Registration District No. **45745-**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Worth**
(b) City or town **Grant City**
(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

3. (a) PRINT FULL NAME **Doble Cordie Early**

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 **wid**

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 **75** Months **4** Days **1** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **April 22, 1940** (b) **Clifford Ross**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Worth**
(c) City or town **Grant City**
(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 **2** day **4**
year **1940** 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 _____

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 **P. J. Ross** (M. D. or other) _____

Address **Grant City** _____

SUPPLEMENTARY

