

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10006**

Registration District No. **4** Primary Registration District No. **3001** Registrar's No. **60**

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
316 North Main St. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 14 years years, months or days) _____

3. (a) PRINT FULL NAME Earl B. Attebery
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 Married
6. (b) Name of husband or wife Leatherine Ore Attebery 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased 11-11-1877 (Month) (Day) (Year)

8. AGE: Years 62 Months 3 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Locus Hill Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Grocer

11. Industry or business Grocery Store

MOTHER FATHER { 12. Name John Jefferson Attebery
13. Birthplace Florida Ill. 1 (City, town, or county) (State or foreign country)
14. Maiden name Esther G. Baker
15. Birthplace Edine Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant Leather Ore Attebery

(b) Address 316 N. Main Kirksville Mo.

17. (a) Burial (b) Date thereof 3-11-40 (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation Laplata Cemetery

18. (e) Signature of funeral director Doc Riley

(b) Address Kirksville Mo.

19. (a) 3-11-40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 316 North Main St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9th
year 40 hour 8 minute 20 A.M.

21. I hereby certify that I attended the deceased from June
1930, to Mar 9, 1940;
that I last saw him alive on Mar 9, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to Coronary sclerosis
Hypotension 94P

Due to _____
Other conditions Angina pectoris 4 yrs
(Include pregnancy within 9 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? _____

3 While at work? _____ (Specify type of place) (e) Means of injury _____ 3

23. Signature H. D. McClure (M. D. or other) MD
Address Kirksville Date signed Mar 10 40

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

1
2
2

RECEIVED

District Health Officer No. 10

District File Number 4-40-865

Date Filed APR 16 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.....

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.