

FILED APR 12 1940

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

10062
Do not use this space.

1. PLACE OF DEATH

(a) County Barry Registration District No. 29
(b) Township Flatoreek Primary Registration District No. 5038 Registered No. 8
(c) City Cassville (d) Street No. _____ St. _____
(e) Length of residence in city or town where death occurred 30 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

435 Henry Yerba Plattenburg 2
(a) Residence, No. Cassville, Mo. St. 61 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lilly Plattenburg
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 3, 1855
7. AGE YEARS 85 MONTHS 1 DAYS 0 IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. Farm
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

FATHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dover, Missouri
13. NAME J. S. Plattenburg
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Va.

MOTHER

15. MAIDEN NAME Laura Yerba
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Va.

17. INFORMANT Mrs. Lilly Plattenburg
(ADDRESS) Cassville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Dover, Cemetary DATE Mar. 6 1940

19. FUNERAL DIRECTOR Horine-Culver
(ADDRESS) Cassville, Mo.

20. FILED 4-2- 1940 Shaw Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 3, 1940
22. I HEREBY CERTIFY, That I attended deceased from Feb 3 1934, to Mar. 3 1940
I last saw him alive on Mar 3 1940 Death is said to have occurred on the date stated above, at 2:30 p.m.
The principal cause of death and related causes of importance were as follows:

Hypostatic Pneumonia Date of onset 4/14/40
Hypertrophic Prostate fractured arm 2/1/40
Other contributory causes of importance:
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ 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? _____
If so, specify _____
(Signed) W. H. ... M. D. 30 (Address) Cassville, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS 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.

I X12004

RECEIVED

District Health Officer No. 6,

District File Number HHO-1003

Date Filed APR 9 1940

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STATEMENT BY LICENSED EMBALMER

I, G. E. Coker, Licensed Embalmer No. 3584

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

J. C. Canada L.E. Registered Apprentice No. 225
No. _____ or by _____
working under my personal supervision

Signed G. E. Coker
Licensed Embalmer No. 3584

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10062

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 29

Primary Registration District No. 5038

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Flat Creek, Mo
(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

Henry Gerba Plattenburg

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 m

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 85

Months 1

Days 0

If less than one day _____ hr. _____ min.

9. Birthplace _____

(City, town, or county)

(State 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) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____

(Date received local registrar)

(b) _____

(Registrar's signature)

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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 3 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

Hypostatic pneumonia

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Hypertrophied Prostate
Major findings: fractured arm
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 Apr. 30 - 1940

(c) Where did injury occur? Bed Room (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? in his home

While at work? No (Specify type of place) _____ (Specify means of injury) Fall

23. Signature E E McDaniel (M. D. or other) _____
Address Cassville, Mo signed _____

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

SUPPLEMENTARY

