

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

10647
Do not use this space.

1. PLACE OF DEATH

(a) County Clark Registration District No. 192
 (b) Township Street Home Primary Registration District No. 5267 Registered No. _____
 (c) City _____ (d) Street No. 2 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. John Samuel Christy (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. ~~Single~~ MARRIED, Married (write the word)
 5A. IF MARRIED, WHO WEDDING, OR DIVORCED HUSBAND OF Minnie Christy (or WIFE OF)
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 3-1862
 7. AGE YEARS 77 MONTHS 8 DAYS 10 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. _____
 10. Date deceased last worked at this occupation (month and year) March 1940 11. Total time (years) spent in this occupation Life
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clark Co Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 13 1940
 22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1938 to March 13 1940.
 I last saw him alive on Feb. March 1 1940. Death is said to have occurred on the date stated above, at 4 P.M.
 The principal cause of death and related causes of importance were as follows:
Prostatic Maliter Date of onset _____
 Other contributory causes of importance: 59

FATHER 13. NAME Henry Daniel Christy
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N.Y.

MOTHER 15. MAIDEN NAME Irena J. Shoptaugh
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clark Co Mo.

17. INFORMANT (ADDRESS) Garland Cook Revere, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Revere, Mo DATE March 15 40

19. FUNERAL DIRECTOR (ADDRESS) J. St. Exparhart Revere, Mo.

20. FILED Ma 13 1940 J. L. McConnell Local Registrar.

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? No
 If so, specify _____ (Signed) J. L. McConnell, M. D.
REVERE MO.

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. 10

District File Number 4-20-798

Date Filed APR 10 1940

STATEMENT BY LICENSED EMBALMER

I, G. W. Epperhart, Licensed Embalmer No. 1802

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

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed G. W. Epperhart

Licensed Embalmer No. 1802

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. 10647

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 192

Primary Registration District No. 5269

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Clay Springs
(b) City or town Lanesburg
(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) (Specify whether

3. (a) PRINT FULL NAME John Lemuel Christy
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 _____ Months _____ Days _____ If less than one day _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) March 13 1920 (b) J. L. McConnell (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay
(c) City or town Revere, Rural
(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 Feb day 13 year 1920 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) (c) Means of injury _____

23. Signature J. L. McConnell (M. D. or other) _____
Address Revere Mo Date signed _____

SUPPLEMENTAL

S-10647