

Rev. 6-17-39
 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.

 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

 MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

 State File No. 11236

 Registration District No. 400

 Primary Registration District No. 55520

 Registrar's No. 36

1. PLACE OF DEATH:

- (a) County Jackson
 (b) City or town Perrine Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Jackson County Home for the aged
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 1/2 years 2
 (Specify whether

 In this community _____ years, months or days) 2 1/2

 3. (a) PRINT FULL NAME F. R. Starkey

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

 4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced M

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

 7. Birth date of deceased Jul 7 1873
 (Month) (Day) (Year)

 8. AGE: Years 66 Months 7 Days 7 If less than one day _____ hr. _____ min.

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

 10. Usual occupation meat cutter

 11. Industry or business none

 12. Name Jas Starkey

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

 14. Maiden name B. E. Robinson

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

 16. (a) Informant's own signature Emmet Jackson

 (b) Address Little Bluff mo

 17. (a) Paola Ks (b) Date thereof 3-1-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

 (c) Place: burial or cremation Paola Ks

 18. (a) Signature of funeral director Wilson, Emerald

 (b) Address Paola Ks

 19. (a) 3-7-40 (b) Lana B. Burt
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Jackson
 (c) City or town Little Bluff
 (If outside city or town limits, write "RURAL")
 (d) Street No. J. B. Home
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

 20. DATE OF DEATH: Month May day 29
 year 1940 hour 5 minute P M.

 21. I hereby certify that I attended the deceased from 1-15, 1940, to 2-29, 1940
 that I last saw him alive on 2-29, 1940
 and that death occurred on the date and hour stated above.

 Immediate cause of death Myocardial degeneration Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 J. H. Greene (M. D. or other) _____

 Address Little Bluff Mo Date signed 3-19-40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

W. J. Hard
.....
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.

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

B 40
2539

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11236

Registration District No. 400

Primary Registration District No. 5553B

Registrar's No. 35-

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Prairie
(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 _____ (Specify whether _____)

years, months or days

3. (a) PRINT FULL NAME Funkhouser R. Starkey

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 66 Months 7 Days 7 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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5/3/40 (b) Sarah H. Jones
(Date received local registrar) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 29 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 _____

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 J. W. Greene (M. D. or other) _____
Address Independence Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940

S-11236