

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

Do not use this space.

14233

1. PLACE OF DEATH  
County Katias 2 Registration District No. 267  
Township Missgo Primary Registration District No. 5090  
City (No. ....) St. .... Ward)  
241  
2. FULL NAME George Harry Mickelberry  
(a) Residence, No. Wrenching St. R. F. No.  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male  
4. COLOR OR RACE White  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rosa Lee Mickelberry  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1 - 2 1872  
7. AGE YEARS 66 MONTHS 11 DAYS 2 If LESS than 1 day, .... hrs. or .... min.  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Henry Co. Mo.  
13. NAME William Mickelberry  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois  
15. MAIDEN NAME Mary Greiver S  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Perich, Missouri, Mo.  
17. INFORMANT (ADDRESS) Mrs. Rose Mickelberry  
Wrenching, Mo.  
18. BURIAL, CREMATION, OR REMOVAL  
PLACE Herodrig DATE 1-6 1939  
19. UNDERTAKER (ADDRESS) Robert Arnold  
Croydite, Mo.  
20. FILED Feb 10 1939 Jas. F. McGlinn  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 4 1938  
22. I HEREBY CERTIFY That I attended deceased from Dec 18 1938 to Jan 4 1939  
I last saw him alive on Dec 22 1938 Death is said to have occurred on the date stated above, at 8-20 P.M.  
The principal cause of death and related causes of importance were as follows:  
Apoplexy  
HTN  
Other contributory causes of importance:  
Hypertension  
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? 2nd 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) J. W. Galbreath M. D.  
(Address) W. Va. Mo.

WRITE, PLEASE, 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.

11-9  
1-6-41

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14233

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 267

Primary Registration District No. 5090

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Union  
(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 Mrs. Henry Mickelberry

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 \_\_\_\_\_ year \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

7. Birth date of deceased Jan 9 1872  
(Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 2 If less than one day \_\_\_\_\_ h. \_\_\_\_\_ 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 Union, Henry Co. Mo  
(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) Feb 10, 1939 (b) Mrs G. F. McElenny  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bates

(c) City or town Union - R.F.D.  
(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 1 day 4  
Year 1939 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 J. W. Galbreath (M.D. or other) \_\_\_\_\_

Address Union Mo Date signed \_\_\_\_\_

SUPPLEMENTAL

