

Registration District No. 660Primary Registration District No. 5875a

Registrar's No.

1. PLACE OF DEATH:

(a) County Perry
 (b) City or town Rural
 (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 76-2-20 years, months or days

3. (a) PRINT FULL NAME John H. Voolker 426

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced _____6. (b) Name of husband or wife Anna Voolker 6. (c) Age of husband or wife if alive 74 years7. Birth date of deceased Jan. 31 1864
(Month) (Day) (Year)8. AGE: Years 76 Months 2 Days 20 If less than one day _____ hr. _____ min.9. Birthplace Perry Co. Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name Charles Voolker13. Birthplace Perry Co. Missouri
(City, town, or county) (State or foreign country)14. Maiden name Mary Nanny15. Birthplace Perry Co. Missouri
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Lawrence Voolker(b) Address Perryville Mo17. (a) Burial (b) Date thereof April 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Perryville Mo.18. (a) Signature of funeral director Young & Sons(b) Address Perryville Mo.19. (a) April 23-40 (b) Joe J. Zollner
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Perry
 (c) City or town 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 April day 21
year 1940 hour 7 minute 30 P. M.21. I hereby certify that I attended the deceased from Apr 20, 1940, to Apr 21, 1940
that I last saw him alive on Apr 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Coronary OcclusionDue to Coronary Arteriosclerosis 6 mmDue to Cerebral Arteriosclerosis 1 yr.Chr Myocarditis 6 mm

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 _____

40 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? 50.5

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

23. Signature Oscar A. Carron (M. D. or other) _____Address Perryville Mo Date signed 4-28-40

92C

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.....

Ernest J. Young

Licensed Embalmer No.....

2138

P. O. Address.....

Barnville ma

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **13733**

Registration District No. **660**

Primary Registration District No. **3876a**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Perry**

(b) City or town **Perryville Twp.**
(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 **John H. Voelker**

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 **76** Months **2** Days **20** 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. (b) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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.

20. DATE OF DEATH: Month **apr** day **21** year **1930** 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 **Coronary Occlusion**
Coronary Sclerosis
Cerebral Sclerosis
Chr. myo Carditis
Cerebral Arteriosclerosis

Due to _____

Due to _____

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

Major findings: Of operations _____ **92c**

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) (c) Means of injury _____

23. Signature **Oliver A. Carron** (M.D. or other) _____

Address **Perryville Mo** Date signed _____

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

