

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18354

Registration District No. 294

Primary Registration District No. 5499B

Registrar's No.

1. PLACE OF DEATH:

- (a) County Franklin
- (b) City or town Rural - Central
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: 2
(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)

8. (a) PRINT FULL NAME W. R. Shrvock 620

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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
65 hr. min.

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

10. Usual occupation Retired S11. Industry or business Druggist12. Name _____ S

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 (Burial, cremation, or removal) (b) Date thereof May 26, 1940 (Month) (Day) (Year)(c) Place: burial or cremation Theriac, Mo.18. (a) Signature of funeral director Charles J. ... 2670n ...(b) Address St. Clair, Mo.19. (a) May 9, 1940 (b) W. R. Duckworth (Registrar's signature) (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Franklin
- (c) City or town Rural 0 (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 May day 22 year 1940 hour 10 minute 15 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 acute myocarditis

Due to _____

Due to 43 W

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) not(b) Date of occurrence May 22, 1940(c) Where did injury occur? at home (City or town) (County) (State)

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

While at work? no (Specify type of place) Means of injury none23. Signature W. R. Duckworth 2670n ...Address Theriac, Mo Date signed 5/24/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Licensed Embalmer No. *3601*

P. O. Address *St. Clair, Mo*

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.