

FILED JUN 22 1940
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

836 Primary Registration District No. _____

Registrar's No. 359

I. PLACE OF DEATH:

(a) County Stoddard Mo
(b) City or town near Parma
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard
(c) City or town near Parma
(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.

3. (a) PRINT FULL NAME

David Atchley White

8. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July-30 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 22 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Elmer White
18. Birthplace Mo. (City, town, or county) (State or foreign country)
14. Maiden name Vertie Atchley
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Father Elmer White
(b) Address Parma Mo

17. (a) Burial (b) Date thereof April-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director Louise J. Bon
(b) Address Campee Mo

19. (a) May 15 1940 (b) Laura Hopkins
(City or town) (Date) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1940 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from Apr. 3, 1940, to Apr. 22, 1940
that I last saw him alive on April 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral spinal meningitis
Due to: Mennefococcus B.

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? 803

(Specify type of place) While at work _____ (e) Means of injury _____
23. Signature Geo W. Husted (M. D. or other) _____
Address Parma, Mo Date signed 7/2/40

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

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

RECEIVED

District Health Officer No. 2,

District File Number 640-1111

Date Filed 6/6/40

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.

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.