

AUG 21 1940

State File No. _____

Registration District No. 653

Primary Registration District No. 5864

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town 3 mi west south - Rural
(c) Name of hospital or institution: County Farm
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 yrs, 4 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot
(c) City or town 3 mi. Rural
(If outside city or town limits, write "RURAL")
(d) Street No. County Farm
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME John A. Viers

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 47 yrs

7. Birth date of deceased. July (Month) 4th (Day) 1940 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>5</u>	<u>4</u>	hr. _____ min. _____

9. Birthplace Mcrary Co, Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Frank Viers

13. Birthplace not known
(City, town, or county) (State or foreign country)

14. Maiden name Sally Fawbush
not known

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

16. (a) Informant's own signature Newey Randolph

(b) Address Pemiscot County Farm

17. (a) BURIAL (b) Date thereof 7 5 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation County Farm

18. (a) Signature of funeral director Newey Randolph

(b) Address 3 mi. Rural

19. (a) 7/6/40 (b) Leola Kelley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5 year 1940 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 1937 to July 5 1940 and that I last saw him alive on July 5 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 36 hrs a poplexy

Due to old age - Arterio Sclerosis

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations None

Of autopsy None

Duration 36 hrs
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 Fredh. Ogilvie (M. D. or other) _____

Address Carruthersville Mo Date signed 7/5/40

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.

8-40-11

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25927**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **653**

Primary Registration District No. **5864**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Pemiscot**
(b) City or town **Hayti**
(c) Name of hospital or institution **County Farm**
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Pemiscot**
(c) City or town **Hayti 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.

3. (a) PRINT FULL NAME

John A Viers

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 **w**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **Feb 1 1878**
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

62 72

2

4

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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **7/6/40**

(To be received local registrar)

(b) **Pearl Kelley**
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____ 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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

