

Registration District No. 539 Primary Registration District No. 144B Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
 (b) City or town Keokuk
 (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 Waid Harker 626
 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 _____
 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
2 10 13 _____ 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. (a) Informant's own signature _____
 (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) 7-51 / (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Stoddard
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
 year 1940 hour 6:05 minute _____ M.
 21. I hereby certify that I attended the deceased from July 23
 _____, 1940, to July 26, 1940.
 that I last saw him alive on July 24, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acidosis + dehydration
 Due to Dysentery, non-specific
 Due to _____

Other conditions (include pregnancy within 3 months of death) 130

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?

While at work? _____ (Specify type of place)
 Means of injury _____
 23. Signature S. M. Sarno (M, D. or other)
 Address Morehouse Date signed 7-27-40

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

I X19511

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH SERVICES
DIVISION OF ANATOMY
1501 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94115

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

264712
number
State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 839

Primary Registration District No. 836101

Registrar's No.

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Ray, Mo. / Richland Twp.
(c) Name of hospital or institution: Ray, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard
(c) City or town Ray Ridge, Mo.
(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 Robert Wade Harter

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 _____

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 2 Months 10 Days 13 If less than one day _____ 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. (a) 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) 9-1-40 (b) J.P. Brenden (Date received local registrar) (Registrar's signature)

MENTION CERTIFICATION

20. DATE OF DEATH: Month July day 26 year 1940 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 _____

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.M. Sarno (M. D. or other) _____

Address warehouse _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

