

FILED AUG 23 1940
 11-10-39
 7-5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

26512

State File No.

Registration District No. 875

Primary Registration District No. 3039

Registrar's No. 172

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

1. PLACE OF DEATH:
 (a) County Vernon
 (b) City or town Nevada
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
304 E. Douglas
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community unknown 80 years
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Vernon
 (c) City or town Nevada
 (If outside city or town limits, write "RURAL")
 (d) Street No. 304 E. Douglas
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME John Melbern Foland

3. (b) If veteran, name war 210 8. (c) Social Security No. none

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 7, 1953
 (Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Ross County Tenn.
 (City, town, or county) (State or foreign country)

10. Usual occupation Cabman

11. Industry or business odd job 9

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 Robert Miller

(b) Address 673 West 2nd, Nevada

17. (a) Burial (b) Date thereof July 15, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clark Cemetery

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Nevada, Mo.

19. (a) 7-19-40 (b) Allen V. Daye
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13, year 1940 hour 11: minute 15 A.M.

21. I hereby certify that I attended the deceased from 7-13 1940, to 7-13 1940 that I last saw him alive on 7-13 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Ch. nephritis

Due to Senility

Other conditions Generalized arteriosclerosis
 (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? 705
 While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature E. Braxton Jones (M. D. or other) _____
 Address Roger Bldg Nevada Date signed 7-15-40

RECEIVED

District Health Officer No. 7,

District File Number 8-40-1193

Date Filed 8-9-40

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 Personal

....., Registered Apprentice No.

working under my personal supervision.

Signed Lloyd R. Winscott

Licensed Embalmer No. 3857

P. O. Address Wesley, 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.