

SEP 25 1940
Registration District No. 68A

Primary Registration District No. 5905

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Bowling Green Rural Cuivre
(If outside city or town limits, write "RURAL" and name of township)
(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 2
(Specify whether
In this community
years, months, & days)

3. (a) PRINT FULL NAME John Robert Best 230
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 M

6. (b) Name of husband or wife Best 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased October 4 1866
(Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 4 If less than one day hr. min.

9. Birthplace Knox Co. Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER
12. Name Henry Best
13. Birthplace South Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Osborne
15. Birthplace South Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss J.R. Best

(b) Address Bowling Green, Mo

17. (a) burial (b) Date thereof 8-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Pisgah Cemetery

18. (a) Signature of funeral director Walter B. Bess
(b) Address Bowling Green Mo

19. (a) Aug 12 (b) W. Wimmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike
(c) City or town Bowling Green 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8
year 1940 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 10
1940 to Aug 8 1940
that I last saw him alive on Aug 8 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Duration _____

Due to Chronic nephritis

Due to _____

Other conditions Operation from prostatic ✓
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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? Yes

(e) Means of injury _____ (Specify type of place) _____
While at work? _____

23. Signature W. Wimmer (M. D. or other) _____
Address Bowling Green, Mo Date signed 8/8/40

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.

1940

181

374

RECEIVED

District Health Officer No. 10

District File Number 9-40-1698

Date Filed SEP 5 1940

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 Yves Bartshead

Licensed Embalmer No. 22046

P. O. Address Baltimore

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29376**

Registration District No. **684**

Primary Registration District No. **5912**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Rice
(b) City or town Conroe
(If outside city or town limits, write "RURAL" and name of township)
(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

John Robert Best

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 m

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 73 Months 10 Days 4 If less than one day _____ 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 _____ (City, town, or county) (State or foreign country)

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) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(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.

20. DATE OF DEATH: Month Aug day 8 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 Chronic Myo carditis

Chronic nephritis

Due to _____
Other condition Prostatectomy
(Include pregnancy within 3 months of death)

Major findings: Of operations Prostate hypertrophy

Of autopsy 127

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? _____
(Specify type of place)
While at work _____ (e) Means of injury _____

23. Signature Roger Berryman (M. D. or other) _____
Address Bowling Green, Mo Date signed 10/2/40

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

SUPPLEMENTAL

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

