

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29872

Registration District No. 838 Primary Registration District No. 4509 Registrar's No.

1. PLACE OF DEATH: *Stoddard*
 (a) County *Stoddard*
 (b) City or town *Dexter*
 (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) *2*
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME *Unnamed 636*
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *Boy* 5. Color or race *white* 6. (a) Single, widowed, married, divorced *wid.*
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased *Aug 1940*
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day *# hr. 15 min.*

9. Birthplace *Dexter* (City, town, or county) *MO* (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name *Amey Eugene Porter*
 13. Birthplace *Campbell MO* (City, town, or county) (State or foreign country)
 14. Maiden name *Betty Lou Courter*
 15. Birthplace *Campbell MO* (City, town, or county) (State or foreign country)

16. (a) Informant *Mrs. Edith Porter*
 (b) Address *Dexter MO*

17. (a) *Burial* (b) Date thereof *Aug 23 1940*
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation *Woodlawn Cem. Campbell*

18. (a) Signature of funeral director *No. Undertaker*
 (b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State *MO* (b) County *Stoddard*
 (c) City or town *Dexter*
 (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 *23rd* year *1940* hour _____ minute *6 A.M.*

21. I hereby certify that I attended the deceased from *Aug. 23rd 1940* to *Aug. 23rd 1940* that I last saw her alive on *Aug. 1940* and that death occurred on the date and hour stated above.

Immediate cause of death *Premature Birth*
 Due to *Cause Unknown*

Due to _____
 Other conditions *5A*
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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? *755* (Specify type of place) _____ (c) Means of injury _____
 23. Signature *D. P. Cannon* (M.D. or other) *DO.*
 Address *Dexter* Date signed *9/16/40*

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

RECEIVED

District Health Officer No. 2

District File Number 940-1489

Date Filed 9/18/40

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

222659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **29872**

Registration District No. **838**

Primary Registration District No. **4509**

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Stoddard

(b) City or town Centerville
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Tom named

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

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

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 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Queen Eugene Carter

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 9/2 1940 Jennie Benton
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Aug day 23
year _____ 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 _____

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 _____

MISSOURI STATE BOARD OF HEALTH
SUPPLEMENTARY

