

FILED AUG 9 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

300097

Do not use this space.

1. PLACE OF DEATH

(a) County Washington Registration District No. 687
 (b) Township Keokuk Primary Registration District No. 6187
 (c) City or (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

John Portney
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|--|---|
| 3. SEX <u>m</u> | 4. COLOR OR RACE <u>w</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>child</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>child</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 8 1940</u> | | |
| 7. AGE YEARS | MONTHS | DAYS |
| | | <u>20</u> |
| If LESS than 1 day, hrs. or min. | | |
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. | |
| | 9. Industry or business in which work was done, as saw mill, bank, etc. | |
| | 10. Date deceased last worked at this occupation (month and year) | |
| | 11. Total time (years) spent in this occupation | |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Bless Mo</u> | | |
| FATHER | 13. NAME <u>John Portney</u> | |
| | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Richwood Mo</u> | |
| MOTHER | 15. MAIDEN NAME <u>Mary Deibel</u> | |
| | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Bless Mo</u> | |
| 17. INFORMANT (ADDRESS) <u>John Portney Bless Mo</u> | | |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Richwood</u> DATE <u>April 28, 1940</u> | | |
| 19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Sparks Pators 808</u> | | |
| 20. FILED <u>May 1 1940 G.F. Cozwell</u> Local Registrar | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 27 1940

22. I HEREBY CERTIFY, That I attended deceased from April 8, 1940, to April 27, 1940.
 I last saw him alive on April 25, 1940. Death is said to have occurred on the date stated above, at 4A m.
 The principal cause of death and related causes of importance were as follows:
Jaunderic

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no.
 If so, specify
 (Signed) Joseph L. Thurman M. D.
 (Address) Pators, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

1618

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. 20097

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 887

Primary Registration District No. 6187

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Washington
(b) City or town Kingston
(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

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.

3. (a) PRINT FULL NAME Charley Bertney
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr day 27
year 1940 hour _____ minute _____ M.

4. Sex M 5. Color or race W
6. (a) Single, widow, married, divorced Chief
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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 _____)

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____
8. AGE: Years _____ Months _____ Days 20 If less than one day _____ hr _____ min

Due to Some congenital condition of malformation of bil. ducts.
Duration 2 days
Other conditions _____
(Include pregnancy within 3 months of death) 159 mm

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) _____
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

Other conditions _____
(Include pregnancy within 3 months of death) 159 mm

Major findings:
Of operations _____

Of autopsy _____

Duration
2 days
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)

(Specify type of place) _____ (Specify type of place)

23. Signature Joseph L. Thurman (Date or other) _____

Address Patrol _____ Date signed 3-6-41

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

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 300097

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 887

Primary Registration District No. 6187

Registrar's No.

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Washington
(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 Chaley Partney

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 child

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 year min.
20

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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 apr day 27 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death Jaundice
N. H. P.

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 (M. D. or other)

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY