

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31882

Registration District No. 258

Primary Registration District No. 4167

Registrar's No. 11

1. PLACE OF DEATH:
(a) County De Kalb
(b) City or town Clarksville
(c) Name of hospital or institution: Clarksville
(d) Length of stay: In hospital or institution 20
In this community 60 years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County De Kalb
(c) City or town Clarksville
(d) Street No. 0
(e) If foreign born, how long in U. S. A. ? years

3. (a) PRESENT FULL NAME: FIVE RHAKERS
3. (b) If veteran, name war: L
3. (c) Social Security No. L

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sep day 29th year 1940 hour 2 minute 0 P.M.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife: L 6. (c) Age of husband or wife if alive: years

21. I hereby certify that I attended the deceased from 1916 to 1940; that I last saw him alive on Sept. 24th 1940; and that death occurred on the date and hour stated above.

7. Birth date of deceased: 1940 (Month) 24 (Day) (Year)
8. AGE: Years 87 Months 8 Days unknown hr. min.

Immediate cause of death: Mitral insufficiency
Due to: Paralysis, Partial 1916
Due to:

9. Birthplace: Kentucky (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: 9

Other conditions: (Include pregnancy within 3 months of death)
Major findings: D. L. Verbins
Of operations: none
Of autopsy: none

MOTHER FATHER { 12. Name: unknown
13. Birthplace: unknown (City, town, or county) (State or foreign country)
14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) (State or foreign country)

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

16. (a) Informant: Mrs. Robert R. Papp
(b) Address: Clarksville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sep - 30 - 40 (Month) (Day) (Year)
(c) Place: burial or cremation: Thornton Cemetery
18. (a) Signature of funeral director: John G. Bean
(b) Address: Clarksville, Mo.
19. (a) Oct 4 - 1940 (Date received local registrar) (b) Mrs. C. M. Davis (Registrar's signature)

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?
23. Signature: D. L. Verbins, M.D. (M. D. or other)
Address: Clarksville, Mo. Date signed: 10/4/40

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

920

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **31882**

Registration District No. **258**

Primary Registration District No. **4157**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Dekalb**

(b) City or town **Clarkdale**
(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 **Ewert A. Nero**

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 **s**

6. (b) Name of husband or wife.

6. (c) Age of husband, or wife, if alive. year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **87** Months **8** Days If less than one day 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.

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) **11-18-1940** (Date received local registrar) (b) **D. L. Perkins, M.D.** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County. **1**

(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 **sep** day **29**
year hour minute M.

21. I hereby certify that I attended the deceased from 19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date and hour stated above.

Medical Certification

Immediate cause of death **myocardial insufficiency**

Due to **Paralysis partial**

Due to **Cerebral Hemorrhage**

Other conditions **Cerebral Hemorrhage - Contributing**
Paralysis of right side

Major findings:
Of operations. **g. h.**

Of autopsy.

Duration **1937**
1939
1932

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 **D. L. Perkins** (M. D. or other)
Address **Clarkdale** Date signed **11-18-1940**

