

No. 2  
4-13-40  
4-17-40  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Wyhojia 32379  
State File No.

FILED OCT 18 1940

Registration District No. 249

Primary Registration District No. 5613

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town SPRING HOLLOW TWP.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution BRUCE RT. LEBANON MO  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2  
(Specify whether years, months or days)

In this community 2 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. BRUCE RT. LEBANON MO  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME EARL DENNIS MIZER

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 \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased JULY 27 1940  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>2</u>	<u>2</u>	hr. _____ min. _____

9. Birthplace SPR. HOLLOW TWP. LACLEDE CO MO  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name CLARENCE MIZER

13. Birthplace NEBANON MO  
(City, town, or county) (State or foreign country)

14. Maiden name EDNA MAY WORLEY

15. Birthplace WEBB CITY MO  
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Mizer

(b) Address Lebanon Mo Bruce RT.

17. (a) Burial (b) Date thereof SEPT 30 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LOWERY CEM.

18. (a) Signature of funeral director Palmer 404

(b) Address Lebanon Mo

19. (a) 10-1-40 (b) J. M. Coust  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 29  
year 1940 hour \_\_\_\_\_ minute 12.30 A. M.

21. I hereby certify that I attended the deceased from July 27  
1940 to Sept 29 1940  
that I last saw h.i.m. alive on Sept 9 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Internal Hemorrhage 2 hrs. Duration

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)

(c) Means of injury \_\_\_\_\_

23. Signature Wm. J. Wajuhja (M. D. or other) M.D.  
Address Lebanon Mo Date signed 9/30/40

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

3

102

RECEIVED

District Health Officer No. 7,

District File Number 10-40-1372-B

Date Filed 10-7-40

**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 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

State File No. **32379**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **449**

Primary Registration District No. **5613**

Registrar's No. ....

1. PLACE OF DEATH:

(a) County **Laclede**  
(b) City or town **Spring Valley Twp**  
(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

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 **Earl Dennis Mizer**

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 \_\_\_\_\_

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  
**2 2** 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 \_\_\_\_\_  
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) \_\_\_\_\_ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Sept** day **29** 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 **Internal hemorrhage**

Due to **Spontaneous pulmonary hemorrhage**

Due to **hemorrhage**

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 **Wm. W. Walsby** (M. D. or other) **md**

Address **Walsby** Date signed **12/17/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

