

FILED OCT 23 1940

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

32742  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Oregon Registration District No. 532  
 (b) Township Couch Oak Grove Primary Registration District No. 0887  
 (c) City Couch (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME** Martin L. Biffle

(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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)  
married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ethel Mae McMakin

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 2 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
57 5 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 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) Sep 21 1940 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alton Mo. 0

FATHER 13. NAME Joseph Biffle 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 9

MOTHER 15. MAIDEN NAME ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shenon Co Mo

17. INFORMANT (ADDRESS) Mrs Marvin Biffle Couch mo

18. BURIAL, CREMATION, OR REMOVAL PLACE New Salem DATE Sept 23 40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rev. C. W. Shayer mo

20. FILED Oct. 4 1940 Lola E. Johnson Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 22 40

Z I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 22 m. Sept.

The principal cause of death and related causes of importance were as follows:

Heart trouble

Date of onset

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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) R. C. Kellith

(Address) Shaver Mo

**RECEIVED**

District Health Officer No. 5,

District File Number. 10401012

Date Filed \_\_\_\_\_

*2000*

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**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.**

2B  
21-40  
K22659

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32742

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 632

Primary Registration District No. 5847

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Oregon  
(b) City or town Park Grove  
(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  
In this community years, months or days (Specify whether)

3. (a) PRINT FULL NAME Marion L. Biffle

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

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

8. AGE: Years 57 Months 5 Days 20 If less than one day min.

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

10. Usual occupation farmer

11. Industry or business general farming

MOTHER FATHER

12. Name Joseph Biffle

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) 701-30-1540 (Date received local registrar) (b) Lola E. Johnson (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 Sept day 22 year 1940 hour minute M.

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

Immediate cause of death Heart trouble

Due to Mitral stenosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 92N

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 C. C. Kellett Cor. (M. D. or other)

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

