

Registration District No. _____ Primary Registration District No. **6207**

1. PLACE OF DEATH: **Carter**
 (a) County **Carter**
 (b) City or town **Ellsinore (rural)**
 (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 **13** years
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Carter**
 (c) City or town **Ellsinore (rural)**
 (d) Street No. _____
 (e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME **Edward Serr**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
 20. DATE OF DEATH, Month **Oct** day **10**
 year **1940** hour _____ minute **38** 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.

4. Sex **M** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Agnes**
 6. (c) Age of husband or wife if alive **65** years
 7. Birth date of deceased **Sept 16 1868**
 (Month) (Day) (Year)

Immediate cause of death **Pneumonia**
 Duration _____

8. AGE: Years **72** Months **0** Days **26**
 If less than one day _____ hr. _____ min.

9. Birthplace **Manchester Penn**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
 12. Name **Adams Serr**
 13. Birthplace **Erie Penn**
 14. Maiden name **Erlie Heavley**
 15. Birthplace **Germany**
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **Agnes Serr**
 (b) Address _____

17. (a) **Burial** (b) Date thereof **10/11/40**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Smith Cem, Ellsinore**

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? _____

18. (a) Signature of funeral director **W. W. M. D. Serr**
 (b) Address **W. W. M. D. Serr**
 19. (a) **Oct 15 1940** (b) **W. W. M. D. Serr**
 (Date received local registrar) (Registrar's signature)

23. Signature **W. W. M. D. Serr** (M. D. or other) _____
 Address _____ Date signed _____
 (Specify type of place) _____
 While at work (e) Means of injury _____

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE 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

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed J. Allen Harris Jr.

Licensed Embalmer No. 4253

P. O. Address Don Green

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. 35028

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 144

Primary Registration District No. 2207

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County. Barber

(b) City or town. Belgium T.P.
(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 Edw Serr

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. m

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 72 Months 0 Days 26
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. _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. _____

18. (a) Signature of funeral director. _____

(b) Address. _____

19. (a) _____ (b) _____
(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.

20. DATE OF DEATH. Month Oct day 11
year 1970 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 Pneumonia
Bronchial Pneumonia

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 J. M. McArthur (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL COPY

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

