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

Registration District No. **725** Primary Registration District No. **4431** Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH**  
(a) County **Ralls**  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution **Rural Center Township**  
(d) Length of stay: In hospital or institution **6 days**  
In this community \_\_\_\_\_ years, months or days

**3. (a) PRINT FULL NAME** **FERN-YANCE-ALESHIRE**  
**8. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

**4. Sex** **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Single**  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if** \_\_\_\_\_

**7. Birth date of deceased** **October - 28 - 1913**  
(Month) (Day) (Year)

**8. AGE:** Years **26** Months **11** Days **22** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** **Montrose, Illinois**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **Laborer**

**11. Industry or business** **Pipe Line**

**12. Name** **C. C. Aleshire**

**13. Birthplace** **Montrose, Illinois**  
(City, town, or county) (State or foreign country)

**14. Maiden name** **May Wallace**

**15. Birthplace** **Montrose, Illinois**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **C. C. Aleshire**

**(b) Address** **Montrose, Illinois**

**17. (a) Removal** \_\_\_\_\_ **(b) Date thereof** **Oct. 21, 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **Montrose, Ill.**

**18. (a) Signature of funeral director** **Dale Bishop**

**(b) Address** **Greenup Ill.**

**19. (a) Nov 1 40** **(b) [Signature]**  
(Date received local registrar) (Registrar's signature)

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

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **20<sup>th</sup>** day **October**  
year **1940** hour **3** minute **30 P.**

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_  
**21a. No medical attention**, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

**Immediate cause of death** **Unavoidable accident**

**Due to** **fracture at Base of skull**  
**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) **Accident**

(b) Date of occurrence **October 20 1940**

(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? **Yes**  
**Pipe Line Construction**  
While at work? **Yes** (Specify type of place) (e) Means of injury **fractured**

**23. Signature** **Clayde C. Wilkey**  
**Address** **Permyro Ralls Co.** **Date signed** **11/21/40**

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

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**RECEIVED**

District Health Officer No. 10

District File Number 11-40-2189

Date Filed NOV 18 1940

**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

*Clyde C. Wilkey*

Licensed Embalmer No. 38208

P. O. Address Peru, Mo.

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36116

Registration District No. 725

Primary Registration District No. 4431

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Ralls

(b) City or town Center 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

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 Fern Vance Aleshire

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20  
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.

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 \_\_\_\_\_ years

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

Immediate cause of death Irreversible accident

fracture at base of skull

8. AGE:

Years	Months	Days	If less than one day
<u>26</u>	<u>11</u>	<u>22</u>	hr. _____ min. _____

Due to Struck in Base of skull by rock from dynamite Blast

Other conditions \_\_\_\_\_  
(Include pregnancy within \_\_\_\_\_ months of death)

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)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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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)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) acc

(b) Date of occurrence Oct 20 1940

(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?  
On a farm while working on Peppin  
While at work (Specify type of place)

(e) Means of injury Coronet

23. Signature Clyde E. Wilkey  
Address Perry, Mo Date signed 12/17/40

SUPPLEMENTAL

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

