

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36654

FILED NOV 25 1940

State File No. _____

Registration District No. 892

Primary Registration District No. 6794 41541

Registrar's No. 7

1. PLACE OF DEATH:
 (a) County Wayne
 (b) City or town Williamsville
 (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 2
 In this community Life (all of) (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Wayne
 (c) City or town Williamsville
 (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 JASPER MARYIN MARKHAN
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex M **5. Color or race** W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** 0 years
7. Birth date of deceased Aug. 27 1899
 (Month) (Day) (Year)

8. AGE: Years 61 Months 1 Days 5 If less than one day hr. _____ min. _____

9. Birthplace Wayne County Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Retired

12. Name Jackson Marion Markhan
13. Birthplace Perm
 (City, town, or county) (State or foreign country)

14. Maiden name Olson Lawson
15. Birthplace Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Strong
(b) Address Williamsville

17. (a) Burial, cremation, or removal Chapel Hill **(b) Date thereof** Oct 5, 1940
 (Month) (Day) (Year)

18. (a) Signature of funeral director Chap - Jester
(b) Address Greenville Mo

19. (a) Oct 5, 1940 **(b)** Mr. Hattie McPhu
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4th
 year 1940 hour 3 minute A M.
21. I hereby certify that I attended the deceased from 9-1-1934
10-4, 1930, to 10-4, 1940
 that I last saw him alive on 10-3, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 3 days
 Due to Bedfast 12 yrs.
 Due to Arthritis Deformans 12 yrs.

Other conditions (Includes 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? _____

816 (Specify type of place) _____
 While at work? Means of injury _____
23. Signature Dr. N. Burton (M. D. or other) _____
Address San Bureau, Mo **Date signed** 10-8-40

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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

J. Allen Harris Jr

Licensed Embalmer No. *4053*

P. O. Address *W. B. ...*

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. 36654

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 892

Primary Registration District No. 4541

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Williamsville
(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 _____ (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

Jasper Marvin Markhan

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH Month Oct day 7 year _____ hour _____ minute _____ M.

4. Sex m 5. Color or race w
6. (a) Single, widowed, married divorced wid
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)

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.

8. AGE: Years Months Days If less than one day
61 | 1 | 5 | _____ min.

Immediate cause of death
Myocardial infarction
Bedfast
Arthritis Deformans
Other conditions (include pregnancy within 3 months of death)
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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 _____ (State or foreign country) _____

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)

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

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

