

Registration District No. 904

Primary Registration District No. 6213

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

1. PLACE OF DEATH:

(a) County Worth  
 (b) City or town Rural Union township  
 (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  
 (Specify whether  
 In this community Life  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth  
 (c) City or town Rural Grant City, Mo  
 (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.

8. (a) PRINT FULL NAME JOHN WESLEY MERCKLING

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Emma Myrtle Merckling (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 12 1872  
 (Month) (Day) (Year)

8. AGE: Years 67 Months 11 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Grant city Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation farmer

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

12. Name Charles Edward Merckling  
 13. Birthplace Union township  
 (City, town, or county) (State or foreign country)

14. Maiden name Alma M. Clark  
 15. Birthplace Union township  
 (City, town, or county) (State or foreign country)

16. (a) Informant Emma Merckling

(b) Address Grant City, Mo

17. (a) Burial (b) Date thereof 10/28/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethel Church

18. (a) Signature of funeral director John C. ...

(b) Address Grant City, Mo  
 19. (a) 10/28/1940 (b) Mrs. O. H. Bond  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26  
 year 1940 hour 12 30 minute A 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 Heart Failure

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? 826

While at work? 5 (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Lawling (M. D. or other) Coroner  
 Address Sheldon Mo Date signed 10-28-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

2002

**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 Arch: C. Duffell

Licensed Embalmer No. 32572

P. O. Address Grant City

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. **36690**

Registration District No. **904**

Primary Registration District No. **6215**

Registrar's No. ....

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

**1. PLACE OF DEATH:**  
 (a) County Worth  
 (b) City or town Wesson, 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** John Wesley Mercedes  
**3. (b) If veteran,** \_\_\_\_\_ **3. (c) Social Security** \_\_\_\_\_  
name war 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 67 Months 11 Days 14 If less than one day \_\_\_\_\_  
hrs. 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 26  
 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 \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

**Immediate cause of death** Heart failure

**Due to** myocarditis

**Other conditions** \_\_\_\_\_  
(Include pregnancy within 3 months of death) 93A1

**Major findings:**  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

**Duration** \_\_\_\_\_  
**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)  
**(e) Means of injury** \_\_\_\_\_

**23. Signature** Subling Coroner  
(M. D. or other)  
 Address Shelburne Date signed 11/4/41

SUPPLEMENTAL COPY

