

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

38620

Do not use this space.

FILED DEC 16 1940

1. PLACE OF DEATH

(a) County Dunklin Registration District No. 283
(b) Township Raffle Primary Registration District No. 5402 Registered No. _____
(c) City Cardwell (d) Street No. _____
(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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. DONNIE MAX _____ St. _____
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-22-15
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
6 15

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cardwell Mo.

FATHER 13. NAME E. G. Lincoln
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marble Hill Mo.

MOTHER 15. MAIDEN NAME Fancy Johnston
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brookland Ark.

17. INFORMANT (ADDRESS) E. G. Lincoln
Cardwell Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Union Dale DATE Nov 13 1940

19. FUNERAL DIRECTOR (ADDRESS) W. J. Emerson
400 Wagon Wheel Rd.

20. FILED 12-12-40 W. J. Emerson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 11 1940

22. 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 12:30 p.m.
The principal cause of death and related causes of importance were as follows:
Date of onset

Bronchial Pneumonia Bilateral 11-1-40

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? none Was there an autopsy? no

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) M. C. Glasgow, M. D.

(Address) Cardwell Mo

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.

1074

RECEIVED

District Health Officer No. 2,

District File Number 1040-182

Date Filed 12/15/40

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed.....

..... Licensed Embalmer No.

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38620

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 283

Primary Registration District No. 5402

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Buffalo 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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Donnie May Lincoln

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 8

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) _____

8. AGE: Years Months Days If less than one day
6 13 _____ min.

9. Birthplace (City, town, or county) _____ 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 (Month) (Day) (Year)

(Burial, cremation, or removal) _____

(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 mo (b) County Dunklin
(c) City or town Cardwell
(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 11 day 11
year _____ 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 Bronchial pneumonia

Due to _____

Due to _____

Other conditions (Include pregnancy within 9 months of death) None

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 W. C. Glasgow (M. D. or other) _____

Address Cardwell mo Date signed _____

Duration 1 week
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

