

Registration District No. **408**

Primary Registration District No. **3020**

Registrar's No. **216**

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Carthage**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1010 Front St.
(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 **57 years**

3. (a) PRINT FULL NAME **John Milton Belknap**
3. (b) If veteran _____ 3. (c) Social Security name war _____ 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 _____
alive _____ years
7. Birth date of deceased **May 30, 1864**
(Month) (Day) (Year)

8. AGE: Years **76** Months **5** Days **29** If less than one day _____ hr. _____ min.

9. Birthplace **Danville, Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Albert J. Belknap**
13. Birthplace **New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Cost**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary J. Belknap**
(b) Address **1010 Front, Carthage**

17. (a) **Burial** (b) Date thereof **Nov. 30, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bank Cemetery**

18. (a) Signature of funeral director **Wm Mortuary**
(b) Address **Carthage, Mo.**

19. (a) **Nov. 30, 1940** (b) **G. J. Mc Intire, M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jasper**
(c) City or town **Carthage**
(If outside city or town limits, write "RURAL")
(d) Street No. **1010 Front St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **29**
year **1940** hour **6** minute **10 A.M.**

21. I hereby certify that I attended the deceased from **Aug 10**, 19**35**, to **Nov 29**, 19**40**
that I last saw him alive on **Nov 28**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Rectum & Lower Intestine**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 **G. J. Mc Intire** (M. D. or other) _____
*Address **Carthage Mo** Date signed _____

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

FILED DEC 1 1940

4b

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. W. K. [Signature]

Licensed Embalmer No. 814

P. O. Address Carthage 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 38871

Registration District No. 408

Primary Registration District No. 3020

Registrar's No. 216

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(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 Milton Belknap

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 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)

8. AGE: Years 76 Months 5 Days 29 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 _____ (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 Nov day 29 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 Cancer of Rectum
46 hours Interested

Due to From observations & findings
I placed the seat of the condition

Due to in the lower descending colon which
is right above the T 10 of the vertebrae

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 46

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 K. E. Baker (M. D. or other)

Address Carthage Mo Date signed _____

SUPPLEMENTARY

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

S-38871 1940