

o. 2  
10-39  
7-30

DEC 12 1940

Registration District No. **605**

Primary Registration District No. **6089359**

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

1. PLACE OF DEATH:

(a) County **New Madrid, Mo.**  
(b) City or town **Risco, Mo.**  
(c) Name of hospital or institution: **Home**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2**  
In this community **10 months** (Specify whether years, months or days)

8. (a) PRINT FULL NAME **Lennie Ray Earnhart**

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

4. Sex **male** 5. Color or race **W** 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 **Jan. 16, 1940**  
(Month) (Day) (Year)

8. AGE: Years **10** Months **6** Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Risco, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

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

12. Name **Virgil Winkler Earnhart**

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

14. Maiden name **Pauline Henderson**

15. Birthplace **Bertrand, Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Virgil Earnhart**  
(b) Address **Risco, Mo.**

17. (a) **Buried** (b) Date thereof **Nov-18-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Parma**

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) **12-4-40** (b) **Dr. Leonard Hunter**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **New Madrid**  
(c) City or town **Risco, Mo.** **Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Sen. Dist.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **17<sup>th</sup>**  
year **1940** hour **11** minute **15 P.M.**

21. I hereby certify that I attended the deceased from **Oct 25**, 19**40** to **Nov 17**, 19**40**.  
that I last saw him alive on **Nov. 12**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Purpura**  
**Branch pneumonia 2 days**

Due to \_\_\_\_\_  
Due to **Acute bacillary dysentery.** **3 weeks**

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: **None** **17<sup>th</sup>**  
Of operations \_\_\_\_\_  
Of autopsy **None**

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?  
**534**  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **M. O. Leonard** (M. D. or other) **M.D.**  
Address **Fortyville, Mo.** Date signed **11-17-40**

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

RECEIVED

District Health Officer No. 2

District File Number 1240-181

Date Filed 12/12/40

**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

Licensed Embalmer No.

P. O. Address

**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.**