

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39505  
2033  
State File No. 689  
Registrar's No.

Registration District No. 689 Primary Registration District No. 3033

1. PLACE OF DEATH:  
(a) County Peke  
(b) City or town Louisiana  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
None - 515 N Carolina  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 60 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Jacob Smith Mix  
3. (b) If veteran, name war no  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Evelyn Keith  
6. (c) Age of husband or wife if alive ✓ years  
7. Birth date of deceased 8/7-1854  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 3 23 hr. min.

9. Birthplace W. Va.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Carpenter

11. Industry or business  
MOTHER FATHER  
12. Name Robert Mix : 5  
13. Birthplace \_\_\_\_\_ : 5  
(City, town, or county) (State or foreign country)  
14. Maiden name Araugh Trout  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Leta Mix Bentley  
(b) Address Louisiana Mo  
17. (a) Burial (b) Date thereof 12/2/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Frankford Mo  
18. (a) Signature of funeral director J. C. Harty  
(b) Address Louisiana Mo  
19. (a) 11/30/40 (b) J. C. Harty  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Peke  
(c) City or town Louisiana Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 515 N Carolina  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 30  
year 1940 hour 9 minute 00 a. M.  
21. I hereby certify that I attended the deceased from 6/3/35  
\_\_\_\_\_, 19\_\_\_\_, to 11/30, 1940;  
that I last saw him alive on 11/20  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis  
Due to Bronchopneumonia

Due to \_\_\_\_\_  
Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations none  
autopsy None

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) none  
(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?  
6-2-40 (Specify type of place) \_\_\_\_\_  
While at work (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Louisiana Mo Date signed 11/30/40

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

MARGIN RESERVED FOR BINDING

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

50M-5-17-39 Rev. 5-17-39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should list CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

RECEIVED

District Health Officer No. 10

District File Number 17-40-2243

Date Filed DEC 7 1940

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.....

*George O. Wagner*

Registered Apprentice No.....

working under my personal supervision.

Signed *George O. Wagner*

Licensed Embalmer No. 3773

P. O. Address *Louisiana, 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

State File No. 39505

Registration District No. 689

Primary Registration District No. 3033

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

1. PLACE OF DEATH:

(a) County Louisiana  
(b) City or town Louisiana  
(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 Jacob Smith Mix  
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 wid  
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 86 Months 3 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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) 11-30-40 (b) [Signature]  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 11 day 30  
year 1940 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 \_\_\_\_\_  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include 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? \_\_\_\_\_

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Louisiana Date signed \_\_\_\_\_

SUPPLEMENTARY

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

ROWENA MOORE

1940  
S-39505

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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.....

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, fact should be so stated above.**