

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42849**

REG. JAN 25 1940
Registration District No. **408**

Primary Registration District No. **3020**

Registrar's No. **223**

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:
1136 South Maple 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 Sixteen years
years, months or days

8. (a) PRINT FULL NAME John Minning
8. (b) If veteran, name war None **8. (c) Social Security** No. None

4. Sex Male **5. Color or race** White **6. (a) Single, widowed, married,** divorced Married
6. (b) Name of husband or wife Elsie **6. (c) Age of husband or wife if** alive _____ years
7. Birth date of deceased. April 8, 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Columbus Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer & Stockman

11. Industry or business 1
12. Name Unknown 9
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Elsie Minning
(b) Address 1136 South Maple St. Carthage
17. (a) Burial, cremation, or removal Burial **(b) Date thereof** Dec 10, 1940
(Month) (Day) (Year)
(c) Place: burial or cremation Chillicothe, Missouri

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Missouri
19. (a) Dec 9, 1940 **(b) E. G. McEntire, M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jasper
 (c) City or town Carthage Missouri
(If outside city or town limits, write "RURAL")
 (d) Street No. 1136 South Maple St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 9th
 year 1940 hour 6 minute 15 A. M.

21. I hereby certify that I attended the deceased from 6/18/40
 19____ to 12/9/40 19____
 that I last saw him alive on Dec 8, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis **Duration** 2 days
Due to myocardial infarction 1 Year

Due to _____
Other conditions None **(Include pregnancy within 3 months of death)** 1/4/40

Major findings: None **PHYSICIAN** _____
Of operations None **Underline the cause to which death should be charged statistically.**
Of autopsy None

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. J. Harris **(M. D. or other)** MD
Address Carthage, Mo **Date signed** 12/9/40

FEB 25 1942

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

John D. Batchelder

Licensed Embalmer No. *4153*

P. O. Address *Canthage 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.