

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

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

44041

State File No.

Registrar's No.

JAN 23 1941

Registration District No. 814

Primary Registration District No. 6068

1. PLACE OF DEATH:

(a) County Scott
 (b) City or town Benton Rural
 (c) Name of hospital or institution: County Old Folks Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
 In this community 15 years
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
 (c) City or town Bikeston Rural Root 'ad
 (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.

8. (a) PRINT FULL NAME Andrew J. Herrick

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 6 1875
 (Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 11 If less than one day hr. _____ min. _____

9. Birthplace Lyon County Kentucky
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business 1

12. Name unknown

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

14. Maiden name unknown

15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature W.O. Finney
 (b) Address Chaffee Mo

17. (a) Burial (b) Date thereof 10-18-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo
 18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) 10-17-40 (b) Zyman Touch
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17
 year 1940 hour 1 minute a M.

21. I hereby certify that I attended the deceased from Oct 15, 1940, to Oct 17, 1940
 that I last saw him alive on Oct 16, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Embolism of Infarct - apoplectic seizure Duration 2 days

Due to Arterial hypertension & Bronchial asthma

Due to Several years

Other conditions Injury to knee 10 days ago
 (Include pregnancy within 3 months of death)

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? Farm

While at work? Yes (Specify type of place) (e) Means of injury Tractor

23. Signature W.O. Finney (M. D. or other) ✓
 Address Box 262, Chaffee Mo Date signed 10/17/40

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

82K

RECEIVED
District Health Officer No.
District File Number 141-12
Last Filed 1/16/40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44041
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 814

Primary Registration District No. 6268

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

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Moreland 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

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.

3. (a) PRINT FULL NAME Andrew J. Merrick

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17 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.

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 _____ year

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

Immediate cause of death Embolism apoplectic nature

| Duration |
|----------|
| _____ |

8. AGE: Years 65 Months 1 Days 11 If less than one day _____ hr. _____ min.

Due to arterial hypertension, Bronchial asthma

Due to several years of

Other conditions: Injury to knee
(Include pregnancy within 6 months of death)

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

Major findings: Contusion of knee said to have been caused by repairing a farm tractor on a farm near Sikeston

PHYSICIAN _____

Underline the cause to which death should be ascribed.

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) _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur _____ (City or town) _____ (County) _____ (State) _____

Did injury occur in or about home, on farm, in industrial place, in public place? Injury did not contribute to death

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

23. Signature W. O. Jones (M. D. or other) _____

Address Box 119, Osage Mo. Date signed 10/19/40

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

SUPPLEMENTARY

