

RECORDED FEB 25 1949

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Winkleville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Laughlin Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 17 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler
(c) City or town Dawning Mo (Rural) OO
(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 William J. Curry

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 Married

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

7. Birth date of deceased Oct 4 1879
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name Orral H. Curry

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

14. Maiden name Rachel Harris

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

16. (a) Informant Mrs. Mary A. Curry
(b) Address Dawning Mo

17. (a) Camp Ground (b) Date thereof Feb 7 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Herb & Basket

(b) Address Murphy, Mo.

19. (a) Feb 11-41 (b) Spencer L. Sneeden
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4
year 1941 hour 6 minute 23 P. M.

21. I hereby certify that I attended the deceased from Jan 18, 1941, to Feb 4, 1941;

that I last saw him alive on Feb 4, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease
hypertension

Due to _____

Due to _____

Other conditions Hypertension
(Include pregnancy within 5 months of death) 5 yrs

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? _____

While at work? 3 (Specify type of place) _____ (e) Means of injury 9

23. Signature Ed H. Lang (M. D. or other) DO

Address Kirkville Mo Date signed 4/14

Duration ?
2 yrs
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

132
RECEIVED

District Health Officer No. 10

District File Number 2-41-366

Date Filed FEB 19 1941

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.....

Albert C. Genth

Licensed Embalmer No. 3689

P. O. Address.....

Memphis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1532
Registrar's No. 57

Registration District No. 1 Primary Registration District No. 1

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Turnersville
(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 Wm. G. Curry
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 m

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)

8. AGE: Years 71 Months 4 Days 0 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) _____ (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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 4 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Pericarditis
Nephritis (chronic)

Due to _____
Due to _____ 131

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

Major findings:
Of operations _____
Of autopsy _____

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? _____

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

23. Signature E. H. [unclear] (M. D. or other) DO
Address _____ Date signed _____

SUPPLEMENTARY

S-1532