

1-10-39
1-17-39
I X21492

Registration District No. 1

Primary Registration District No. 200

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Nouinger
(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 30 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Adair
(c) City or town Nouinger (If outside city or town limits, write "RURAL.")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

8. (a) PRINT FULL NAME Benjamin Mear

3. (b) If veteran, name war ✓ 8. (c) Social Security No. MEAR

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife single 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Nov - 4 - 1869
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 26 If less than one day hr. min.

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

10. Usual occupation news

11. Industry or business

12. Name Phillip Mear

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

14. Maiden name David Mear

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

16. (a) Informant J. Mear

(b) Address Nouinger

17. (a) Burial (b) Date thereof Feb - 1 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nouinger

18. (a) Signature of funeral director Spencer L. Freeman

(b) Address Nouinger Mo

19. (a) Feb - 1 - 1941 (b) Spencer L. Freeman
(Date received by registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30
year 1941 hour 4:00 minute M.

21. I hereby certify that I attended the deceased from July 1, 1940 to Jan 30, 1941
that I last saw him alive on Jan 1, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Heart Disease
Due to ✓

Due to ✓
Other conditions (Include pregnancy within 3 months of death) grippe

Major findings: Of operations ✓
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 A. T. Garrison, M.D.
Address Nouinger Mo Date signed 3-30-41

Duration 2 yrs

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

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

RECEIVED

District Health Officer No. 10

District File Number 2-41-385

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.....

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. 1539

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1

Primary Registration District No. 200

Registrar's No.

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Nowmeyer, Ia
(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 Benquesman Mer

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, single

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

7. Birth date of deceased Nov 4 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

71 2 26 hr. min.

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

10. Usual occupation _____

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)

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) Mar. 29/41 (b) James L. Freeman
(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.

20. DATE OF DEATH: Month 1 day 30
year _____ 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 _____

Due to _____

Due to _____

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

23. Signature J. T. Garrison (M. D. or other)
Address Nowmeyer, Ia Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

S-1559