

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.

MAR 17 1941

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

8398 +

Do not use this space.

1. PLACE OF DEATH

(a) County Stone
 (b) Township James Ruth
 (c) City James Ruth

Registration District No. 845-108Primary Registration District No. 6108Registered No. 0

(d) Street No. 1 (If death occurred in Hospital or Institution, write its name instead of street and number) St. A
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. 0

2. PRINT FULL NAME

(a) Residence, No. John Henry Black
Ruth Sp. Stone Co. Mo

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED OR DIVORCED
 HUSBAND OF Gertrude Black
 (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 26 1874

7. AGE YEARS 66 MONTHS 2 DAYS 9 If LESS than 1 day,hrs. ormin.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stone Co. Mo ()13. NAME John Henry Black14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo ()15. MAIDEN NAME Don't Know16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo ()17. INFORMANT Mrs. Gertrude Black
(ADDRESS) Peeds Spring Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Country Graveyard DATE Feb. 05 1941

19. FUNERAL DIRECTOR (NAME) Ernest Cheatham
 (ADDRESS) Galena Mo

20. FILED 2/4/41 19 41 L. S. Shumate
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1941 19

22. I HEREBY CERTIFY That I attended deceased from Did not attend, 19.....
 I last saw him alive on 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Internal injuries caused by being crushed under a truck load of logs. Accidental

Date of onset

Other contributory causes of importance:

Probable rupture of liver & other organs

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Auto wreck on public roadNature of injury Internal abdominal organs crushed

24. Was disease or injury in any way related to occupation of deceased?

If so, specify L. S. Shumate M. D.(Signed) L. S. Shumate(Address) Peeds Spring Mo

RECEIVED

District Health Officer No. 6.

District File Number 341-393

Date Filed MAR 7 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. 8398

Registration District No. 840

Primary Registration District No. 6108

Registrar's No. _____

1. PLACE OF DEATH

- (a) County Stoner T.P.
(b) City or town Barth 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 _____ years, months or days)

3. (a) PRINT
FULL NAME

John Henry Black

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 _____ years

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

8. AGE: Years 66 Months 2 Days 9 If less than one day 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 (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____ (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 _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____

- that I last saw him _____ alive on _____ and that death occurred on the _____ day and hour stated above

- Immediate cause of death Internal injuries by being crushed under a truck Duration _____

- Due to accidental over turning of auto truck

- Due to probably rupture of liver & other organs

- Other conditions _____ (Include pregnancy within 3 months of death)

- Major findings: No operation

- Of operations _____

- Of autopsy No autopsy

- 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) Accident

- (b) Date of occurrence _____

- (c) Where did injury occur? Autos wreck on public rd (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place? On public highway

- (Specify type of place)

- While at work? _____ (e) Means of injury _____

23. Signature L S Shumate (M. D. or other) _____

- Address Reeds Spring Date signed 5/17/41

SUPPLEMENT

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD—DO NOT WRITE IN PENCIL

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8398

Registration District No. 845-

Primary Registration District No. 6108

Registrar's No. _____

1. PLACE OF DEATH

(a) City or town Ruth
(If outside city or town limits, write "RURAL" and name of township)
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 John Henry Black

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 _____ years

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

8. AGE: Years 66 Months 2 Days 9 If less than one day _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2/4/41 (b) L.S. Shumate (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 Feb day 4 year 1941 hour About 9 AM 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 L.S. Shumate (M. D. or other) _____

Address Reed Springs Mo Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

HOWENSON

SUPPLEMENTARY

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.)

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