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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

APR 11 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10238

State File No.

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 95

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Fulton MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 mo 18 days  
(Specify whether Y in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Randolph  
(c) City or town Asheer MO  
(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? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 29  
year 1941 hour 5 minute PM  
21. I hereby certify that I attended the deceased from July 11, 1940, to Mar 29, 1941;  
that I last saw him alive on Mar 29, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death General Paralysis  
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 M. K. Pope (M. D. or other) D  
Address Fulton MO Date signed 4/27/41

Duration  
? 30/12  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME James Terrell

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. DR

4. Sex Male 5. Color or race Col 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 Aug 4 1897  
(Month) (Day) (Year)

8. AGE: Years 43 Months 7 Days 25 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Asheer MO (City, town, or county) (State or foreign country) 0

10. Usual occupation Fabricator

11. Industry or business \_\_\_\_\_

12. Name Walter Gurrell

13. Birthplace Asheer MO (City, town, or county) (State or foreign country) 0

14. Maiden name Walterine Gurrell

15. Birthplace Asheer MO (City, town, or county) (State or foreign country) 0

16. (a) Informant State Hospital Record

(b) Address Fulton MO

17. (a) Removal (b) Date thereof 4-3-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia MO

18. (a) Signature of funeral director G. O. Roberts

(b) Address Columbia MO 106  
19. (a) April 3, 1941 (b) R. N. Crews  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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**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.**