

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 384

Primary Registration District No. 5325

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell
 (b) City or town "Rural" Howell Twp.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
West Plains, Mo. / Siloam Springs, Rt.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution No.
(Specify whether years, months or days)
 In this community All of life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. West Plains, Siloam Rt.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 8
 year 1941 hour 12 minute 10 P.M.

21. I hereby certify that I attended the deceased from March 6, 1941 to March 8, 1941;
 that I last saw him alive on March 8, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death pneumonia, bronchial bilateral, acute Duration 5 days

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
 Of operations No operation

Of autopsy No 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 H. H. Thorpburgh (M. D. or other) md
 Address West Plains, Mo. Date signed 3/11/41

3. (a) PRINT FULL NAME BOBBY DEAN WOMACK

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 0

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

7. Birth date of deceased March 25, 1940
(Month) (Day) (Year)

8. AGE: Years 0 Months 11 Days 13 If less than one day
 hr. _____ min. _____

9. Birthplace West Plains, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Francis Womack

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

14. Maiden name Alpha Mae Berry

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

16. (a) Informant's own signature Francis Womack

(b) Address West Plains, Missouri

17. (a) Burial (b) Date thereof Mar. 9, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Howell Twp. Howell Co.

18. (a) Signature of funeral director Hal Stamborgh

(b) Address West Plains, Mo.

19. (a) 3-9-41 (b) Vida W SIMONS
(Date received local registrar) (Registrar's signature)

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.

RECEIVED

District Health Officer No. 5,

District File Number 441479

Date Filed _____

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.