

No. 2
1-4-40
5-17-40
X26390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11032

State File No. _____

APR 9 1941

Registration District No. 416

Primary Registration District No. 4248

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Sarsotic
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether)
In this community 38 years (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Sarsotic
(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 March day 19
year 1941 hour 7:10 minute A M.
21. I hereby certify that I attended the deceased from Dec-15-
1940 to March 19 1941;
that I last saw him alive on March 18 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis ✓
Due to Hypertension
Due to acute arterial dilatation of heart
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
2 mo.
2 or 3 years
few days

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?
9/4/8
While at work? _____ (Specify type of place) _____ (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address Sarsotic Mo. Date signed 3-22-41

3. (a) PRINT FULL NAME Robert H. Herren
3. (b) If veteran, ✓ name war _____
3. (c) Social Security No. ✓

4. Sex MA 5. Color of race M
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Luella
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Jaw 16 1865
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 3
If less than one day hr. _____ min. _____

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

10. Usual occupation Retail laborer

11. Industry or business Railroad

12. Name William Herren

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

14. Maiden name Ember Markum

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

16. (a) Informant Mrs Luella Herren

(b) Address Sarsotic Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/41
(Month) (Day) (Year)

(c) Place: burial or cremation Sarsotic Cemetery

18. (a) Signature of funeral director Roland C. Engle
(b) Address Sarsotic Mo.

19. (a) 3/21/41 (Date received local registrar) (b) [Signature] (Registrar's signature)

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

19
0
0

828

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.....

George B. Orr

Licensed Embalmer No.....

946

P. O. Address.....

W. Yemon

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.

S. No. 2B
4-25-41
I X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11032

Registration District No. 416

Primary Registration District No. 4248

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Barlowie
(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 Robert W. Herken

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 Months Days If less than one day

76 2 3 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) _____
(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 Mar day 19
year 1941 hour _____ minute _____ M.

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

Immediate cause of death Paralysis Duration _____
cerebral hemorrhage
Due to Hypertension
Due to acute dilatation of heart ?

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 [Signature] (M. D. or other) _____

Address Barlowie Mo. Date signed 6-8-41

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

ROWENA MOORE

SUPPLEMENTAL

1941

S-11032