

FILED JUN 6 1941 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

18878
Do not use this space.

1. PLACE OF DEATH

(a) County St. Clair Registration District No. 11037
(b) Township _____ Primary Registration District No. 6012 Registered No. _____
(c) City Harpers or _____ (d) Street No. 1 _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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.

2. PRINT FULL NAME

(a) Residence, No. St. Clair Co. Mo. Piquette (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Mo 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Child
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 13-1928
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
17 6 24
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Student
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) St. Clair Co. Missouri
(STATE OR COUNTRY)

FATHER 13. NAME C. B. McLeary
14. BIRTHPLACE (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Myrtle Harper
16. BIRTHPLACE (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

17. INFORMANT Wm Harper
(ADDRESS) Harper Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Harper Cem DATE 2-10 1941

19. FUNERAL DIRECTOR (NAME) A. S. Johnston
(ADDRESS) Oscar Mo.

20. FILED June 3, 1940 Mrs W F Hudson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-9 1941

22. I HEREBY CERTIFY, That I attended deceased from 2-9- 1941, to 2-9- 1941

I last saw him alive on 2-9- 1941. Death is said to have occurred on the date stated above, at 5 P m.

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

Cerebro-Spinal Meningitis Date of onset 2-7-41
In my opinion this was
caused by mastoiditis or
inflammation of internal 2-1-41
ear. Never saw this case

Other contributory causes of importance:
until about an hour before
he died.

Name of operation None Date of _____

What test confirmed diagnosis? Physical 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 _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) A. S. Johnston M. D.

(Address) D. Wheatland Mo

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. 7
District File Number 6-41-901
Date filed 6-3-41

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.