No. 2
-1-4-41
-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 15 1941

F[illegible]n District No. 4[illegible]

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25354

Primary Registration District No. 3022

Registrar's No. 43

1. PLACE OF DEATH

(a) County Jefferson

(b) City or town De Soto
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Olivia
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 mo. (Specify whether
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson 050

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME John Deery

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced 4

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Aug. (Month) 5 (Day) 1869 (Year)

8. AGE: Years 71 | Months 10 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Farmer

11. Industry or business ____

FATHER
12. Name Daniel Deery
13. Birthplace ____ (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Elizabeth Donnely
15. Birthplace ____ (City, town, or county) Pennsylvania (State or foreign country)

16. (a) Informant Mrs. W. Noce

(b) Address Danby Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-41 (Month) (Day) (Year)

(c) Place: burial or cremation Danby Mo.

18. (a) Signature of funeral director Fink Mud Co.

(b) Address Festus Mo.

19. (a) Aug 1 1941 (Date received local registrar) (b) Mattie Woods (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2nd year 1941 hour 2 a.m. minute — M.

21. I hereby certify that I attended the deceased from July 1st 1941, to July 2 1941 that I last saw him alive on July 1 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	3 days
Due to 23A	
Due to	
Other conditions Non (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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature Walter E. Gibson (M. D. or other) 0

Address De Soto Mo Date signed 7-2-41

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(Licensed Embalmer's Statement on Reverse Side)

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. 3403

P. O. Address. Festus Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
1—8-21-41
P I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25354

Registration District No. 420 Primary Registration District No. 3022 Registrar's No. 43

1. PLACE OF DEATH:

(a) County: Jefferson

(b) City or town: DeSoto

(If outside city or town limits, write "RURAL," and name of township)

(c) Name of hospital or institution: Olivia

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community: 8 mo

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 .....

3. (a) PRINT FULL NAME: John Deery

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: Widowed

6. (b) Name of husband or wife: Unknown

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 ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

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) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) Aug 1-41 (Date received local registrar) (b) Mattie Woods (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day ..... year 1941 hour ..... 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 ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

5-25354