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District Health Officer No: 7,

District File Number: 12-41-2044

Date Filed: 12-12-41

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: *A. J. Durrill*

Licensed Embalmer No. 3786

P. O. Address: *Dadeville, Mo*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39158

Registration District No. 704

Primary Registration District No. 5933

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dick
(b) City or town General
(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

Jan A. Whittenburg

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 S.

6. (b) Name of husband or wife _____

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

7. Birth date of deceased

Feb. 22, 1944
(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

SUPPLEMENTARY

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)

(Date received local registrar)

(b)

(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 _____ Day _____
Year 1944 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 _____

Acute pneumonia
Parental cold for 2 weeks
Due to _____

Due to Attended baby I have seen
several years
Other conditions Yes other complications
(Include any within 3 months of death) that I know of

Major findings: _____

Of operations _____

Of autopsy _____

Duration

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)
(c) Means of injury _____

23. Signature J. Barber M.D. (M.D. or other) _____
Address Walnut Grove Mo _____

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

S-39158