

FILLED DEC 8 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39180
Do not use this space.

1. PLACE OF DEATH
 (a) County Putham Registration District No. 724
 (b) Township York Primary Registration District No. 5955 Registered No. 88
 (c) City Powersville (d) Street No. _____ St. 0
 (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. 0

2. PRINT FULL NAME David A. Varner
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lillie Varner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 27th, 1866

7. AGE YEARS 75 MONTHS 0 DAYS 25 IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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 _____

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana
 13. NAME Newton Varner
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Marguerite Conn,
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana.

17. INFORMANT (ADDRESS) L.D. Varner,
Powersville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Wyreka DATE Oct. 24th 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Beary-Statton Co.,
Powersville, Mo.

20. FILED Oct 24, 1941 Mrs D.W. Pollock
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 22, 1941

22. I HEREBY CERTIFY, That I attended deceased from Sept. 28, 41 to Oct. 22, 1941
 I last saw him alive on Oct. 22, 1941. Death is said to have occurred on the date stated above, at 12 noon
 The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia Date of onset 12/11
 Other contributory causes of importance:
Yangerous Effusion
Sept. 26, 1941

Name of operation Appendectomy Date of 9/28/41
 What test confirmed diagnosis? _____ 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? _____
 If so, specify _____
 (Signed) L. W. McDonald M.D.
 (Address) Powersville, 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. 10

District File Number 12-44-2115

Date Filed DEC 3 1941

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 AM

....., Registered Apprentice No.
working under my personal supervision.

Signed Paul Smith
Licensed Embalmer No. 2634

P. O. Address Quinton

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. 39180

Registration District No. 724

Primary Registration District No. 5955

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town _____
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pulaski
(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 _____

3. (a) PRINT FULL NAME

David A. Turner

3. (b) If veteran name war _____

3. (c) Social Security No. _____

4. Sex M.

5. Color or race W.

6. (a) Single W. widowed, married, divorced _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

Sept 27 1875
(Month) (Day) (Year)

8. AGE:

Years 75 Months 5 Days 15 If less than one day _____ 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 _____

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-10-42

(Date received local registrar)

(b) Mrs. D.W. Pollock
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her 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?
_____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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

SUPPLEMENTARY 22

S-39180