FILED MAR 6 1942

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

8084

Do not use this space. 10

1. PLACE OF DEATH
(a) County Texas — Registration District No. 18
(b) Township or (c) City Morris — Primary Registration District No. 6139 — Registered No. 2
(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 Charles Darrell Mercer O
(a) Residence, No. 11 St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. O
4. COLOR OR RACE W.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single O
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 24 1942
7. AGE YEARS MONTHS DAYS 23 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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) (STATE OR COUNTRY) Texas Co. Mo.

FATHER
13. NAME Roy Mercer
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. O

MOTHER
15. MAIDEN NAME Wilda Crawford
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo O

17. INFORMANT (ADDRESS) Mrs Wilda Mercer R. R. Cabool Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Union DATE Feb 18 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gayford V. Elliott Cabool Mo

20. FILED Feb 20 1942 Pearl E. McCall Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 17 1942

22. I HEREBY CERTIFY, That I attended deceased from Feb 16 1942 to Feb 17 1942
I last saw him alive on Feb 16 1942 Death is said to have occurred on the date stated above, at 8 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Meningitis	Feb 16 42
33 b	
Other contributory causes of importance:	
Influenza	Feb 12 42

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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) Lm Edens M. D.
(Address) Cabool Mo

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
—8-21-41
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. 8084

Registration District No. 18 Primary Registration District No. 6139 Registrar's No.

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Rural
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Texas
(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? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles H. Mercer
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 Jan (Month) 24 (Day) 19 (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) Feb 20-42 (Date received local registrar) (b) Pearl E. McCall (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day
year 1942 hour minute M.
21. I hereby certify that I attended the deceased from to , 19 ;
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)
(b) 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

SUPPLEMENTARY