

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

FILED SEP 15 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28012

Registration District No. 299

Primary Registration District No. 6027

Registrar's No.

1. PLACE OF DEATH:

(a) County Reynolds
 (b) City or town rural, Jackson
(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 Reynolds
 (c) City or town rural, Jackson
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Wm. Carroll Counts.

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 married
 6. (b) Name of husband or wife Ala 6. (c) Age of husband or wife if alive 52 years
 7. Birth date of deceased 7 (Month) 10 (Day) 1871 (Year)

8. AGE: Years 71 Months 1 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation farming

11. Industry or business _____

12. Name Charles Counts
 13. Birthplace Mo (City, town, or county) (State or foreign country)
 14. Maiden name Margaret Burgess
 15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Wilburn Counts
 (b) Address Callington, Mo
 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) Sept 2 1942 (Date received local registrar) (b) Mar Jarey Callington (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21 year 1942 hour 9 PM minute 9 P. M.

21. I hereby certify that I attended the deceased from August 1 1942 to Aug 21 1942

that I last saw him alive on August 1 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis Duration 4 M

Due to _____
 Due to _____

Other conditions Hypertrophied prostate 4 y
(Include pregnancy within 3 months of death)

Major findings: Of operations 1218 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 A. F. Burgess (M. D. or other) Address Callington, Mo Date signed 8-22

RECEIVED

District Health Officer No. 5,

District File Number

Date Filed

942889

9-14-42

This certificate
should have been sent
to Mrs Evans at Ellington
Mo. I am sorry I signed
the certificate.

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 the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28012
Registrar's No. _____

Registration District No. 299 Primary Registration District No. 6027

1. PLACE OF DEATH:
(a) County Reynolds
(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 _____ (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 Wm. Cornell Counts
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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 10 1942
(Month) (Day) (Year)
8. AGE: Years 21 Months 1 Days 10 (If less than one day, hr. min.)

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

10. Usual occupation _____
11. Industry of 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 Wilburn Counts
(b) Address Ellington Mo

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) July 2 1942 (b) Max Pines Wellington
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 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 _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration

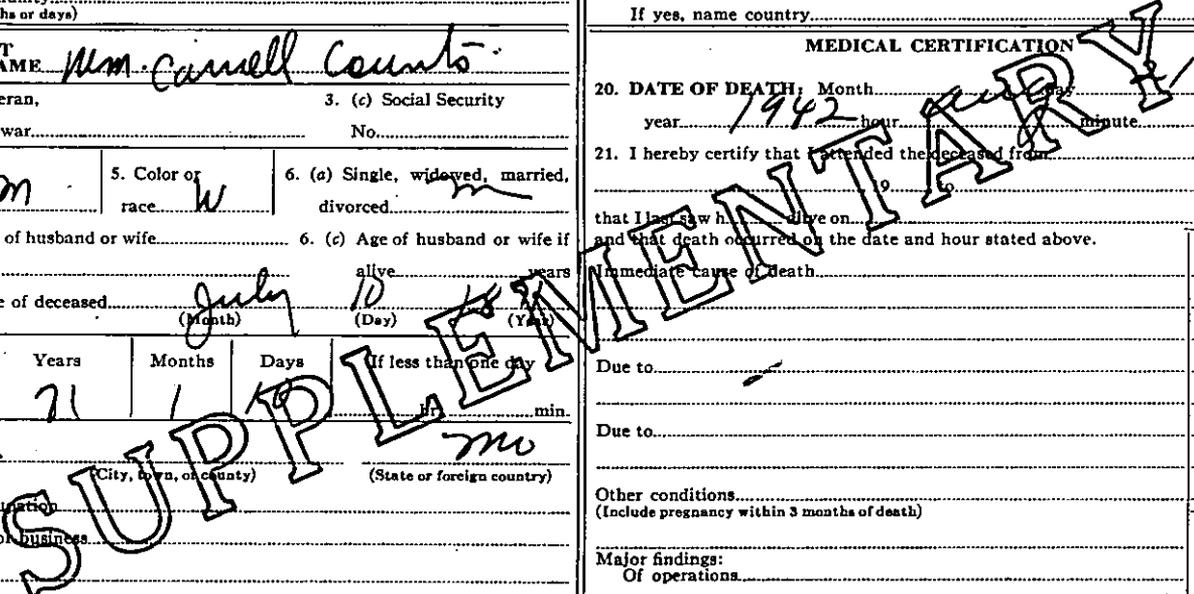
PHYSICIAN

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

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



STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 300

Primary Registration District No. 6029

Registrar's No.

1. PLACE OF DEATH:

(a) County..... Reynolds

(b) City or town..... rural - Logan
(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

In this community..... LIFE
years, months or days) (Specify whether)

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 Wm Carroll Counts

3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
..... 19..... to..... 19.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced..... M

6. (b) Name of husband or wife..... etc 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased 7 - 10 - 1877
(Month) (Day) (Year)

that I saw him..... die on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

8. AGE: Years Months Days (If less than one day)
71 1 11 min.

Duration

Due to.....

Due to.....

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

Other conditions.....
(Include pregnancy within 3 months of death)

10. Usual occupation.....

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry of business.....

12. Name.....

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

14. Maiden name.....
(City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

17. (a) Burial (b) Date thereof Aug 22 - 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Counts Cemetery

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

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

(b) Address.....

(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.....

19. (a) Nov 1 - 42 (b) Fannie Evans
(Date received local registrar) (Registrar's signature)

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

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

MOTHER FATHER

SUPPLEMENTARY