

34209

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED NOV 13 1944

Registration District No.

Primary Registration District No.

Registrar's No.

13184

3039

34

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Marceline
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 55 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn
(c) City or town Marceline
(If outside city or town limits, write "RURAL")
(d) Street No. 201 W Howell (If rural, give location)
(e) If foreign born, how long in U. S. A.? 90 years

3. (a) PRINT FULL NAME JOSEPH HEMMINGS

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased April 15 1848
(Month) (Day) (Year)

8. AGE: Years 94 Months 6 Days 3 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry of business _____

12. Name Samuel Hemmings

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

14. Maiden name Sarah Priddy

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

16. (a) Informant's own signature Mrs. G. A. Smith

(b) Address 624 N. Springfield Josephine Mo

17. (a) Burial (b) Date thereof 10/20/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olivet

18. (a) Signature of funeral director James M. Laughlin

(b) Address Marceline

19. (a) 10-21-1944 (b) W. W. Cowan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18 year 1942 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from June 1, 1942, to Oct 17, 1942; that I last saw h. alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration _____

Due to acute Myelitis

Due to General Arteriosclerosis

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

Major findings: Of operations 930

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 P. J. Peterson (M. D. or other) _____
Address Marceline Mo Date signed 10/20/42

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

Rev. 5-17-39 I X1511

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.

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.....

Dale Bunch

Licensed Embalmer No.....

4088

P. O. Address.....

Marceline 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.