

No. 12-40
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11671

ED APR 14 1943

State File No. _____

Registration District No. 340

Primary Registration District No. 6151

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Elk (Rural)
(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 _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard
(c) City or town Lavalle
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23
year 1943 hour 7 minute 45 P.M.
21. I hereby certify that I attended the deceased from Feb 23
1943 to Feb 23 1943;
that I last saw him alive on Feb 23 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia 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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Dr. Scott Husted (M. D. or other) MS
Address Paris Mo. Date signed Feb 24-1943

3. (a) PRINT FULL NAME Thelbert Gene Starnes

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

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

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

7. Birth date of deceased Dec 4 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation mil

11. Industry or business mil

12. Name Oliver Starnes

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

14. Maiden name Ada Rachel Chapman

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

16. (a) Informant Oliver Starnes

(b) Address Lavalle Mo.

17. (a) Burial (b) Date thereof Feb 24, 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parsons Cem.

18. (a) Signature of funeral director W. H. Thompson

(b) Address Starnes Mo.

19. (a) 3-7-43 (b) Carrie Miceel
(Date received local registrar) (Registrar's signature)

1153

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

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RECEIVED

District Health Office No. 2,

District File Number 443-469

Date Filed 4-12-43

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 comply with 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. 11671
Registrar's No. 13

Registration District No. 340 Primary Registration District No. 60-1

1. PLACE OF DEATH:
(a) County Stoddard
(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 _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Shelbert G. Stans
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 5
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 4 1941 (Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 18 (If less than one day _____ min.)

9. Birthplace _____ (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 _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

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 July Year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
that I last saw him/her alive on _____ and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral hemorrhage

Due to _____
Due to No complications

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

Major findings: Of operations 107
Of autopsy _____

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 Clowfus (M. D. or other) _____
Address _____ Date signed 7/12/43

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

SUPPLEMENTARY

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

S-11671