

19271

S. No. 2  
M-9-4-41  
5-17-39  
1 X

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 339

Primary Registration District No. 6150

Registrar's No. 11

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town New Lisbon TWP.  
(If outside city or town limits, write "RURAL" and name of township)

(c) ADVANCE, Mo. / Route 1  
(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 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town New Lisbon, TWP.  
(If outside city or town limits, write "RURAL")

(d) Street No. ADVANCE, Mo. Route 1  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Alexander Midkiff

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month MARCH day 27  
year 1943 hour 6 minute 00 A.

4. Sex MALE 5. Color or race White

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CLARINDA Midkiff

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Feb 6 1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan, 1943, to March 27, 1943  
that I last saw him alive on March 26, 1943  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>1</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death Senility

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation Retired RAILROADER

11. Industry or business SAME

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

12. Name THOMAS Midkiff

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

14. Maiden name NANCY LANCE

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Charles Burdges

(b) Address Advance Mo. R.I.

17. (a) Burial (b) Date thereof MAR. 29/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PLEASANT GROVE

18. (a) Signature of funeral director Walter Gunter

(b) Address Blossfield Mo.

19. (a) 5-6-1943 (b) J. Stimmer  
(Date received local registrar) (Registrar's signature)

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 E.C. Masties (M. D. or other) do.

Address Advance, Mo. Date signed 3/29/43

5215

RECEIVED

District Health Office No. 2,

District File Number 643-747

Date Filed 6-4-43

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 *B. J. Brentlinger*.....

Licensed Embalmer No. *4201*.....

P. O. Address *Dexter, 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, fact should be so stated above.