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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31531

State File No. _____

FILED SEP 21 1943

Registration District No. 89

Primary Registration District No. 5-328-4121 Registrar's No. 368

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Leasburg Mo.
(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 1
(Specify whether _____)

In this community 20 years
years, months or days (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford

(c) City or town Leasburg
(If outside city or town limits, write "RURAL") 028

(d) Street No. _____ (If rural, give location) _____

(e) Citizen of foreign country? American (Yes or No) Y
If yes, name country _____

3. (a) PRINT FULL NAME Charles Rufus Purvins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 27th
year 1943 hour 4 minute P M.

4. Sex MO 5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife Mary Davis

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

7. Birth date of deceased 2 22 - 1859
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 10 1943 to Aug 27 1943
that I last saw him alive on Aug 27 1943
and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: Years 84 Months 6 Days 4 hr. _____ min. _____

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

Due to Myocarditis

Due to _____

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

10. Usual occupation None

11. Industry or business _____

12. Name C. B. Purvins

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

14. Maiden name _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Ben Mullen

(b) Address Leasburg Mo.

17. (a) (Burial, cremation, or removal) Leasburg cemetery

(b) Date thereof 8-29-1943
(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director L. J. Jones

(b) Address Stuebelville Mo.

19. (a) _____ (b) _____
(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 W. F. Durin (M. D. or other) _____

Address Leasburg Mo. Date signed _____

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

0000

RECEIVED

District Health Officer No. 5,

District File Number 943564

Date Filed 9-17-43

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.

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 89

Primary Registration District No. 4125

Registrar's No. 368

1. PLACE OF DEATH
 (a) County Crawford
 (b) City or town Leadburg
 (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..... (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Charles Rufess Purvins
 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 w

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

7. Birth date of deceased Feb 22
 (Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days 1 (If less than one day, min.)

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

10. Usual occupation.....

11. Industry or business.....

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) Aug 28 43 (b) N. F. [Signature]
 (Date received local registrar) (Registrar's signature)

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 Aug day 27
 year 1943 hour 12 minute 00 M.

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

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..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

31531