

OCT 13 1943

Registration District No. 157

Primary Registration District No. 5588

Registrar's No. 186

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Sarcoxie, Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home  
(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 50 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Jasper  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural Route, Sarcoxie  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Junius W. Church

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

7. Birth date of deceased July 10<sup>th</sup> 1875  
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 17 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Isaac James M. Church  
13. Birthplace North Carolina  
(City, town, or county) (State or foreign country)  
14. Maiden name Susan Helgesoche  
15. Birthplace North Carolina  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs June Church

(b) Address Sarcoxie, Mo

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

(c) Place: burial or cremation Sarcoxie, Mo.

18. (a) Signature of funeral director Wm R. Powell

(b) Address Sarcoxie, Mo.

19. (a) Sept. 29 1943 (b) Elizabeth Corplein  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27  
year 1943 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11  
8 1940 to 9-27- 1943  
that I last saw him alive on 9-25- 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Duration 5 days

Due to Stroke of paralysis 3 yrs.

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) (c) Means of injury \_\_\_\_\_  
23. Signature Wm R. Powell (M. D. or other) \_\_\_\_\_  
Address Sarcoxie, Mo. Date signed 9-27-43

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

43-9-841

**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..... *Max. L. Fossett*.....  
Licensed Embalmer No. *4252*  
P. O. Address *Sarcove, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Oct.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Gasper  
 (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 50 yr.  
years, months or days)

3. (a) PRINT FULL NAME Junius W. Church  
 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 97 year  
 7. Birth date of deceased July 10 - 1847  
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days \_\_\_\_\_ If less than one day min.  
 9. Birthplace D. Cur.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
 11. Industry or 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_  
 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Data 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 \_\_\_\_\_

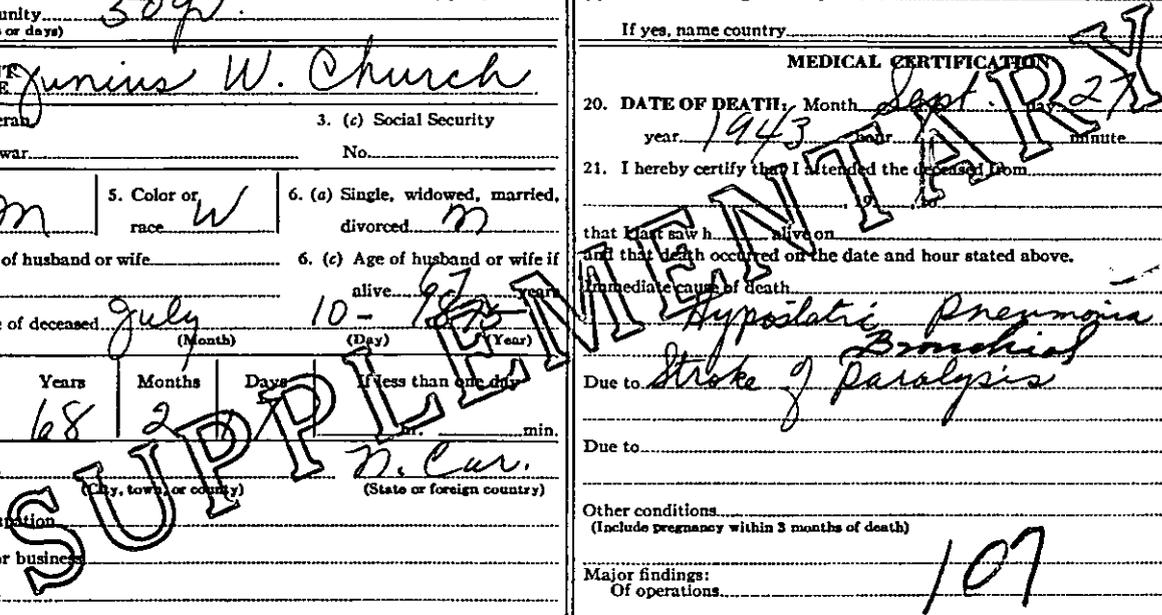
MEDICAL CERTIFICATION  
 20. DATE OF DEATH, Month Sept Day 27 Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia 5 da.  
Stroke of paralysis 3 yr.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions 107  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 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?  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature J. B. York (M. D. or other) \_\_\_\_\_  
 Address Darwin Mo. Date signed 10-16-43

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



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

31827