No. 2
-2-43
-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 9 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

4631

State File No.

Registration District No. 337 Primary Registration District No. 4499 Registrar's No. 13

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

1. PLACE OF DEATH:
(a) County Shelby
(b) City or town Shelbina 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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Shelby 102
(c) City or town Shelbina 2
(If outside city or town limits, write "RURAL") 0
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME George Washington Decker
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 28 (Day) 1861 (Year)

8. AGE: Years 82 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) 9 (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Don't Know
13. Birthplace United States 1 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name ~~Don't~~ Evans
15. Birthplace Don't Know 9 (City, town, or county) (State or foreign country)
16. (a) Informant V. L. Decker
(b) Address Hallsday mo
17. (a) (Burial, cremation, or removal) (b) Date thereof Dec 30 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Shelbina mo
18. (a) Signature of funeral director E Hayes
(b) Address Shelbina mo
19. (a) Feb 3-44 (Date received local registrar) (b) Madge Gooch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from Dec 23, 1943 to Dec 28, 1943 that I last saw him alive on Dec 28, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	5 da
Due to Influenza	4 da
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 33	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature O. R. Denton (M. D. or other) DO
Address Shelbina Mo Date signed Jan 28 44

1043 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-44-383
Date Filed FEB 8 1944

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.

No. 2B
—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb.

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

1. PLACE OF DEATH:
(a) County Shelby
(b) City or town Shelbina
(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 years, months or days)
In this community .....

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 .....

3. (a) PRINT FULL NAME George W. Decker
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 Sept. 28 — 1861 (Month) (Day) (Year)
8. AGE: Years 82 Months 3 Days ..... If less than one day: ..... hr. ..... min.
9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) (State or foreign country)
MOTHER
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) Feb 3 47 (Date received local registrar) (b) Mabel Gooch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28 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	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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

4631