S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10867

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 33

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Nevada (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Nevada Hospital (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 63 years

2. USUAL RESIDENCE OF DEACESED: 104

(a) State Missouri (b) County Vernon 0

(c) City or town Nevada Rural 0 (If outside city or town limits, write "RURAL")

(d) Street No. Mountain View Twp. R#3 (If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Elmer Forrest Zaring

3. (b) If veteran, name war

3. (c) Social Security No. 486-24-0766

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Nellie Zaring

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased June (Month) 10 (Day) 1877 (Year)

8. AGE: Years 67 Months 9 Days 0 If less than one day ..... hr. ..... min.

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

10. Usual occupation Farming

11. Industry or business

MOTHER FATHER

12. Name William Gibson Zaring

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

14. Maiden name Sarah Jane Tamble

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

16. (a) Informant L. T. Evans

(b) Address Garland Kansas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Maple Cemetery

18. (a) Signature of funeral director Perry Funeral Home

(b) Address Nevada, Missouri

19. (a) 3-13-45 (Date received local registrar) (b) Hazel B. Beurck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10 year 1945 hour 2 minute 25 A.M.

21. I hereby certify that I attended the deceased from March 8 1945, 19..., to March 10, 1945 that I last saw him alive on March 10, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Concussion — Duration 39½ hrs

Due to

Due to

Other conditions Head Lacerations + Contusions (Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy NONE

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) Accident

(b) Date of occurrence MARCH 8 1945

(c) Where did injury occur? Farm (City or town) Vernon Co (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Farm (Specify type of place)

While at work? yes (e) Means of injury?

23. Signature W M Allen (M. D. or Coroner)

Address Nevada Mo Date signed March 12 1945

1331 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 3-40-300
Date Filed 4-9-43

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 Me

, Registered Apprentice No.

working under my personal supervision.

Signed L. B. Ferry

Licensed Embalmer No. 1760

P. O. Address Nevada, 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.

S. No. 2B
M—5-43
I X36930

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. April

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 33

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Nevada
(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 Elmer F. Zaring
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 Years
7. Birth date of deceased June 10 (Month) (Day) (Year)
8. AGE: Years 67 Months 9 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Kansas (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 10 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h 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 ADDITIONAL SUPPLEMENTARY INFORMATION
Of autopsy REQUESTED

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 March 8, 1945
(c) Where did injury occur? Rural (City or town) Vernon (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ON FARM (Specify type of place)
While at work? YES (e) Means of injury (OVER)
23. Signature (M. D.)
Address Nevada Mo Date signed 4-28-45

SUPPLEMENTARY

10867

I am unable to specify the means of injury of this man as he was unable to give me this information. The man was conscious when I treated him but when asked by me and others about the cause of his injuries he said he didn't know. Mr. Zaring had gone to the timber on his property in a wagon drawn by a pair of young horses. He later returned to his home in the wagon, his head covered with blood and three severe lacerations involving the face and mouth. There were no fractures of the skull, but the nose was fractured. This man was in a near state of shock, having had a concussion, and the amnesia suffered is not unusual. The family was of the opinion that Mr. Zaring was thrown from the wagon, when the young team became frightened at somthing, or was kicked by one of the horses. I understand that some investigation by the law was made involving the cause of the injury.

Wm H Allen M.D.

Wm. H. Allen, M.D.