No. 2
11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 31 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15993

Registration District No. 386 Primary Registration District No. 4082 Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County Carroll

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

(c) Name of hospital or institution: no. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community All his Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

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

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

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME John Bailey Earp.

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex MALE

5. Color or race White

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

6. (b) Name of ~~husband~~ or wife Myrtle Earp.

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

7. Birth date of deceased Dec (Month) 18 (Day) 1871 (Year)

8. AGE: Years 74 Months 4 Days 15 If less than one day ____ hr. ____ min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name James Earp.
13. Birthplace Tenn. (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name Whitermore.
15. Birthplace Tenn. (City, town, or county) / (State or foreign country)

16. (a) Informant Mrs John Earp.
(b) Address Bogard, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Zion.

18. (a) Signature of funeral director E. R. Dunnerson
(b) Address Bogard Mo.

19. (a) 5-4-1946 (Date received local registrar) (b) Eunice Street (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 3 day 3rd year 1946 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from March 1, 1946, to May 3, 1946; that I last saw h ____ alive on March 19, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to	
Due to	
Other conditions Hypertension (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 94	

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 John H Platz MD (M. D. or other)
Address Carrollton, Mo Date signed 5/4/46

48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 5-29-46

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 Earl Dickerson

Licensed Embalmer No. 2534

P. O. Address Bagard 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, above space should be left blank.

S. No. 2B
25M—3-45
I X43880

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. June

Registration District No. 386 Primary Registration District No. 4082 Registrar's No. 7

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Bogard
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

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

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

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

If yes, name country

3. (a) PRINT FULL NAME John B. Earp.

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 Dec (Month) 18 (Day) 1871 (Year)

8. AGE: Years 74 Months 4 Days 10 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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 May
year 1946 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.

	Duration
Immediate cause of death	
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

15993