

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27653

State File No.

Registrar's No.

FILED SEP 13 1946
Registration District No.

Primary Registration District No. 567742N

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Whiteside, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: XXXX
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XX (Specify whether)
In this community 40 years (years, months or days)

3. (a) PRINT FULL NAME

George Birchfield

3. (b) If veteran,

name war 210

3. (c) Social Security

No. None

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Grace Birchfield 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased July 19 1881 (Month) (Day) (Year)

8. AGE: Years 65 Months 2 Days 3 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business XA

MOTHER FATHER

12. Name Geo. W. Birchfield
13. Birthplace Tenn. (City, town, or county) (State or foreign country)
14. Maiden name Susan O'Brien
15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant Grace Birchfield
(b) Address Whiteside, Mo.

17. (a) Burial (b) Date thereof 8-14-46 (Month) (Day) (Year)

(c) Place: burial or cremation Will Creek Cemetery

18. (a) Signature of funeral director W. R. Dunning

(b) Address Liberty, Mo.

19. (a) Sept 5 '46 (b) Mrs. J. A. Newyer (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lincoln 57
(c) City or town Whiteside (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 August day 12 year 1946 hour 5 minute 45 PM

21. I hereby certify that I attended the deceased from July 23 1946 to August 12 1946 that I last saw him alive on August 1 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration ✓

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 938
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:

(c) 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 0

23. Signature S. B. Hoover (M. D. or other) M.D.
Address Whiteside, Mo. Date signed 8/12/46

164

(Licensed Embalmer's Statement on Reverse Side)

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

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

X 1, Registered Apprentice No. X 1
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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Sept*

Registration District No. *181*

Primary Registration District No. *4295*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Lincoln*
(b) City or town *Whitehead*
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(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

3. (a) PRINT FULL NAME *George Burchfield*

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

7. Birth date of deceased *July 19* (Month) (Day) (Year)

8. AGE: Years *65* Months Days If less than one day hr. 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) (Date received local registrar) (b) *Mrs. J. A. Kueger* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *Lincoln*
(c) City or town *Whitehead*
(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* Year *1946* Hour minute M.

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

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

SUPPLEMENTARY

1954

191

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27653