

No. 2
8-43
17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31054

State File No.

FILED OCT 8 1947

Registration District No. 145

Primary Registration District No. 5566

Registrar's No.

1. PLACE OF DEATH:

(a) County Iron
(b) City or town Rural Deerp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community About 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron 47
(c) City or town Rural C
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? American (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Zack Deery

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife Ann Deery 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 6-18-1863
(Month) (Day) (Year)

8. AGE: Years 84 Months 2 Days 14 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER {
12. Name Unknown
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nellie Key
(b) Address Steelville MO

17. (a) _____ (b) Date thereof 8-22-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Veburnum Cemetery

18. (a) Signature of funeral director L. J. Jones
(b) Address Steelville MO

19. (a) Oct 4 1947 (b) Mrs Elizabeth Logan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 21st
year 1947 hour 4 minute A M.

21. I hereby certify that I attended the deceased from May 1946 to August 1946
that I last saw him alive on Aug 18, 1947 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia 5 da
Due to Tuberculosis (pulmonary) 24.
Due to Senile debility

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 7, B

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? 2

While at work _____ (Specify type of place) (g) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Steelville MO State MO

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 4

District File Number 1047-1286

Date Filed 6-2-47

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 L. J. Jones

....., Registered Apprentice No.
working under my personal supervision.

Signed L. J. Jones

Licensed Embalmer No. 2379

P. O. Address Shelville 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.

Registration District No. 145 Primary Registration District No. 5-566

1. PLACE OF DEATH:
(a) County Iron
(b) City or town Quail
(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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Lack Oenny
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 wid
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased June 6 1861
(Month) (Day) (Year)

8. AGE: Years 84 Months Days If less than one day
hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(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)

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 July Day 1 Year 1947 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 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.....

Due to.....
Due to.....
Other conditions..... (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?
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other)
Address..... Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-31054