

FILED JUL 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20069

State File No. 5598 Registrar's No. 74

|   |  |  |                           |  |  |   |  |
|---|--|--|---------------------------|--|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>164</u>  |                           | PRIMARY REG. DIST. NO. <u>3033</u>   |  | Registrar's No. <u>74</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Johnson</b>   |  |  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <b>Rural Columbus</b>  |  | c. LENGTH OF STAY (In this place) <b>life</b>  |                           | c. CITY (If outside corporate limits, write RURAL and give township) <b>Rural Columbus Twp</b>   |  | d. STREET ADDRESS (If rural, give location) <b>R. R. # 1 Centerview</b> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>RFD1 Centerview Mo.</b>  |  |  |                           | 4. DATE OF DEATH (Month) (Day) (Year) <b>June 25 1949</b>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) <b>William Larkerbrink</b>   |  |  | a. (First) <b>William</b> |  |  | b. (Middle) <b>-----</b>  |  |
| c. (Last) <b>Larkerbrink</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>                                      |                           | 8. DATE OF BIRTH <b>Sept 3, 1861</b>   |  | 9. AGE (In years last birthday) <b>87</b>                               |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>  |                           | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>                        |  |
| 11. BIRTHPLACE (State or foreign country) <b>Johnson Co., Mo.</b>   |  |  |                           | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  |
| 13a. FATHER'S NAME <b>Henry Larkerbrink</b>   |  | 13b. MOTHER'S MAIDEN NAME <b>Katherine McMahan</b>   |                           | 14. NAME OF HUSBAND OR WIFE <b>Mary Elizabeth</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>None</b>  |                           | 17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Jake Billingsley</b>  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                                |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Unknown myocarditis</b> |                           |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>                            |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  | DUE TO (b) _____<br>DUE TO (c) _____   |                           |  |  | 4522  |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |                           |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>/</b>   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                   |                           | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)  |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>     |                           | 21f. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>May 2, 1949</b> , to <b>June 25, 1949</b> , that I last saw the deceased alive on <b>June 25, 1949</b> , and that death occurred at <b>5:30p m.</b> , from the causes and on the date stated above. |  |  |                           |  |  |   |  |
| 23a. SIGNATURE (Degree or title) <b>W. W. Sweeney M.D.</b>  |  |  |                           | 23b. ADDRESS <b>Warrensburg Mo</b>   |  | 23c. DATE SIGNED <b>June 27, 1949</b>                                   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24b. DATE <b>6-27-49</b>   |                           | 24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill Cem.</b>   |  | 24d. LOCATION (City, town, or county) (State) <b>Warrensburg Mo.</b>    |  |
| DATE REC'D BY LOCAL REG. <b>June 27, 1949</b>   |  | REGISTRAR'S SIGNATURE <b>Saranda C. Sweeney</b>  |                           | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Sweeney-Phillips</b>   |  | ADDRESS <b>Warrensburg Mo</b>   |  |

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 6 1943

---

---

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

*W. Jack Phillips*

Licensed Embalmer No. *4566*

P. O. Address *Warrensburg, Mo.*

Signed.....  
Student Embalmer

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.