N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

[redacted] OCT 18 1940

32136
Do not use this space.

1. PLACE OF DEATH
(a) County Henry — Registration District No. 349
(b) Township Tebo — Primary Registration District No. 5-487 — Registered No. 16
(c) City ~~Windsor~~ (d) Street No. ____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 45 yrs. ____ mos. ____ ds. (f) How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. PRINT FULL NAME Charles Walter Avery
(a) Residence, No. Henry Co., Mo. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Male | Colored | Married |

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mattie E. Avery

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 6, 1868

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ____ hrs. or ____ min. |
|---|---|---|---|---|
| | 71 | 10 | 13 | |

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Henry County, (STATE OR COUNTRY) Missouri 0

FATHER
13. NAME Lewis Avery 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 1

MOTHER
15. MAIDEN NAME Sarah N. Brown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT Mrs. Mattie E. Avery (ADDRESS) R.F.D. Windsor, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Sardith Cemetery — Henry Co., Mo. DATE Sept. 21, 1940

19. FUNERAL DIRECTOR R.W. Brauninger (ADDRESS) Leeton, Mo.

20. FILED Sept. 21, 1940 Mrs. Edith J. Simpson Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 19, 1940

22. I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1940, to Aug. 15, 1940
I last saw him alive on Aug. 15, 1940. Death is said to have occurred on the date stated above, at 1:00 P. m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Blood Stream infection | |
| Septic Foot and Left leg. | |

Other contributory causes of importance:

Name of operation None Date of ____
What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ____, 19____
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) W. F. Lodge M.D.
(Address) Leeton, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 10-40-1408
Date Filed 10-8-40

## STATEMENT BY LICENSED EMBALMER

I, R. A. Braunsinger, Licensed Embalmer No. 3377

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

W. A. Braunsinger L. E.

No. ..... or by ....., Registered Apprentice No. .....

working under my personal supervision.

Signed R. A. Braunsinger

Licensed Embalmer No. 3377

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w**
**the above constitutes grounds for revocation of license.)**

. 2B
21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 32136

Registration District No. 349 Primary Registration District No. 3487 Registrar's No. 16

1. PLACE OF DEATH
(a) County Henry Tea Bo T. P.
(b) City or town (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 (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Chas Walter Avery
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race Col
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 (Month) (Day) (Year)

8. AGE: Years 71 Months 10 Days 13 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19
year 1910 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 Blood stream infection septic foot and left leg. | |
| 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?
While at work? (Specify type of place) (e) Means of injury

23. Signature W. J. Riddle M.D. (M. D. or other)
Address Leeton Mo. Date signed

SUPPLEMENTARY