

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

44603
Do not use this space.

JAN 6 1938

1. PLACE OF DEATH

(a) County Saline Registration District No. 798
 (b) Township Watts Fork Primary Registration District No. 6041 Registered No. _____
 (c) City Wassonville (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 1
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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) (STATE OR COUNTRY) Norton, Mo.
 FATHER 13. NAME Newton Deer
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline City, Mo.
 MOTHER 15. MAIDEN NAME Elizabeth Pickens
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Norton, Mo.
 17. INFORMANT (ADDRESS) Newton Deer, Norton, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Norton, Mo. DATE Dec 27, 1938
 19. FUNERAL DIRECTOR (ADDRESS) Wassonville, Mo.
 20. FILED 10-27-1938 O. A. Churchill Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 26, 1938
 22. I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1938, to Oct 26, 1938
 I last saw him alive on Oct. 25, 1938 Death is said to have occurred on the date stated above, at 10:30 A. M.
 The principal cause of death and related causes of importance were as follows:
Premature birth Date of onset _____
 Other contributory causes of importance: None
 Name of operation _____ Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? _____
 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) A. B. Putnam, M. D.
 (Address) Wassonville, Mo.

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.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.....
No..... or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

44603
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1. PLACE OF DEATH

(a) County Saline Registration District No. 798
(b) Township Salt Fork Primary Registration District No. 604
(c) City (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

James Samuel Deer
(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED mf (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 26, 1938

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said to have occurred on the date stated above, at... m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 25, 1938

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 1

Premature birth Date of onset

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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

Other contributory causes of importance: none

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation Date of.....

13. NAME

What test confirmed diagnosis? Was there an autopsy?

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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.

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Feb 21, 1939 E. L. Griswell Local Registrar

24. Was disease or injury in any way related to occupation of deceased? If so, specify (Signed) A. C. Putnam, M. D. (Address) Marshall mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation, if any, should be stated. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be in red ink. If death occurred in hospital or institution, name of institution should be stated. If death occurred in home, name of street and number should be stated. If death occurred in public place, name of place should be stated. If death occurred in vehicle, name of vehicle should be stated. If death occurred in water, name of water should be stated. If death occurred in air, name of air should be stated. If death occurred in fire, name of fire should be stated. If death occurred in other place, name of place should be stated.

