

REC'D MAR 20 1939

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

7259  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Monroe Registration District No. 582  
 (b) Township Jackson Primary Registration District No. 5779 Registered No. 5  
 (c) City Wilt Day (d) Street No. Co. Infirmary 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 WILT DAY  
 (a) Residence, No. Co. Infirmary St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF N. K.  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) N. K.  
 7. AGE YEARS 63 MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. NONE  
 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) N. K. 9  
 13. NAME N. K. 9  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. K. 9  
 15. MAIDEN NAME N. K.  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. K.  
 17. INFORMANT Infirmary Records  
 (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Co. Infirmary DATE Feb. 26 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) NONE  
 20. FILED 2-26 1939 F. A. Barnett M.D. Local Registrar. 910

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 25 1939  
 22. I HEREBY CERTIFY that I attended deceased from Feb 18 1939 to FEB 25 1939  
 I last saw him alive on Feb 25 1939 Death is said to have occurred on the date stated above, at 11:30 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Sucker Pneumonia Date of onset 7/15/34  
 Other contributory causes of importance: 106  
 Name of operation..... Date of.....  
 What test confirmed diagnosis? none 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? yes  
 If so, specify Asst. M.D. Repelle M.D.  
 (Signed) Asst. M.D. Repelle (Address) 910

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.

RECEIVED

District Health Officer No. 10

District File Number 10-39-359

Date Filed MAR 14 1939

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**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 .....

Registered Apprentice No....., 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, above space should be left blank.**