

DEC'D APR 7 1939

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

12546

Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 836
(b) Township Liberty Primary Registration District No. 6098A
(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

(a) Residence, No. Jane Brown St. (If nonresident, give city or town and State)
Prue Mo (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF S. Brown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 25-1883
7. AGE YEARS 55 MONTHS 5 DAYS 9 If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
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) Ill.

FATHER 13. NAME Wm Perry Whitehead

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

MOTHER 15. MAIDEN NAME Sarah Rowan

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

17. INFORMANT Husband (ADDRESS) Bessie

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE 4/4 1939

19. FUNERAL DIRECTOR (NAME) Ray Funeral Home (ADDRESS) Camptell Mo

20. FILED 4-5 1939 Laura Hopkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 3 - 1939

22. I HEREBY CERTIFY, that I attended deceased from April 3, 1939, to April 3, 1939.

I last saw him alive on April 3, 1939. Death is said to have occurred on the date stated above, at 6 P m.

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

Cerebral Hemorrhage Date of onset Apr 3, 1939
92C

Other contributory causes of importance: Arteriosclerosis, myocarditis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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 _____, 1939

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) Bessie, M. D.

(Address) Bessie, Mo

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.