

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.

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

AUG 14 1939

26707  
 Do not use this space.

1. PLACE OF DEATH 2  
 (a) County St. Francois Registration District No. 773  
 (b) Township Farrington Primary Registration District No. 4464  
 or  
 (c) City Farrington Mo Street No. \_\_\_\_\_ (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 Henry Scott Amnette  
 (a) Residence, No. Lang St. Farrington Mo.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>col</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Ebbie (Kullack) Amnette</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov 8th 1868</u>				
7. AGE	YEARS <u>70</u>	MONTHS <u>8</u>	DAYS <u>14</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Laborer</u>			
	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			
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Caledonia Mo</u>			
	13. NAME <u>Henry Amnette</u>			
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Caledonia Mo</u>			
	15. MAIDEN NAME <u>Sarah Green</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>			
17. INFORMANT (ADDRESS) <u>Edmer Amnette Farrington Mo</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Col. Masonic</u> DATE <u>9-24</u> , 19 <u>39</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Verdant m &amp; co Farrington Mo</u>				
20. FILED <u>July 23, 1939</u> <u>B. J. Robinson</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 22, 1939  
 22. I HEREBY CERTIFY That I attended deceased from July 19, 1939, to July 22, 1939  
 First saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 11:20 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Genial Atherosclerosis  
Chronic myocarditis  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 93C  
 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) [Signature], M. D.  
689 (Address) Farrington 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 me

C J Flayd

Registered Apprentice No. \_\_\_\_\_

Merideth road co

working under my personal supervision.

Signed C J Flayd

Licensed Embalmer No. 3527

P. O. Address Farmington M

**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.**