

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 32939Registration District No. 538Primary Registration District No. 5727Registrar's No. 70

1. PLACE OF DEATH:

- (a) County Madison
 (b) City or town Rural - Carter Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None (Specify whether
 years, months or days) years in community

3. (a) PRINT FULL NAME Clarence Oscar White3. (b) If veteran, name war None 3. (c) Social Security No. None4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Leota White 6. (c) Age of husband or wife if alive 39 years7. Birth date of deceased March 24 1885
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
54 5 15 hr. min.9. Birthplace Madison Co. Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Farmer11. Industry or business Farm12. Name John B. White13. Birthplace Madison Co. Mo.
(City, town, or county) (State or foreign country)14. Maiden name Mary White15. Birthplace Madison Co. Mo.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Madison White(b) Address Fredricktown Mo. R.F.D.17. (a) Burial (b) Date thereof Sept 21 39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Highway, Mo.18. (a) Signature of funeral director G. J. Webb(b) Address Fredricktown, Mo.19. (a) Sept 21 1939 (b) S. C. Slaughter
(Date registered local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Madison
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Fredricktown Mo. R.F.D.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19
year 1939 hour 11 minute 05 A.M.21. I hereby certify that I attended the deceased from September 9, 1939 to Sept 18, 1939
that I last saw him alive on Sept 18, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Bronch. Pneumonia 3 days
Cancer of Stomach
" " Liver."

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____Of autopsy None
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) (Means of injury) _____

23. Signature Harold J. ... (M. D. or other)Address Fredricktown Mo Date signed Sept 20 1939

4.6

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.....

Myron A. LaRue....., Registered Apprentice No.....
working under my personal supervision.

Signed *Myron A. LaRue*.....
Licensed Embalmer No. *4025*.....
P. O. Address *Fredricktown Mo.*.....

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32939
Do not use this space.

1. PLACE OF DEATH

(a) County Madison Registration District No. 338
(b) Township Castor Twp Primary Registration District No. 3727
(c) City..... (d) Street No.....
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(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.

Registered No. 70

2. PRINT FULL NAME Clarence Oscar White

(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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
34 5- 15

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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 19 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on 19..... Death is said to have occurred on the date stated above, at.....m.

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

Chronic Pneumonia
Constriction of Stomach
of Liver
Other contributory causes of importance
Primary Nephroses
of Stomach

Date of onset

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..... 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) Harold J. Freilich, M. D.

(Address) Fredericktown Mo

SUPPLEMENT

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

