

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

44442
Do not use this space.

1. PLACE OF DEATH

(a) County Keynes Registration District No. 1108
 (b) Township Mabel Primary Registration District No. 5983
 (c) City _____ or _____ (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. 563 Charles Vineyard St. Reynolds Co. Mo.
 (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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 27 1876</u>		
7. AGE YEARS <u>63</u>	MONTHS <u>9</u>	DAYS <u>11</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		If LESS than 1 day, hrs. or min.
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 <u>0</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Reynolds Co. Mo.</u>		
13. NAME <u>Jim Vineyard</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Washington Co. Mo.</u>		
15. MAIDEN NAME <u>Elyabeth Hampton</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Reynolds Co. Mo.</u>		
17. INFORMANT <u>Oscar Vineyard</u> (ADDRESS) <u>Mabel Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>11-10-39 Mabel Mo.</u> DATE		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Way - Ten Chel</u> <u>Woodman Mo.</u>		
20. FILED <u>12/14</u> 19 <u>19</u> <u>T. D. Piles, M.D.</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 4 1919

22. I HEREBY CERTIFY, That I attended deceased from Dec 4 1919 to Dec 8 1919
 I last saw him alive on Dec 8 1919. Death is said to have occurred on the date stated above, at 11:15 P.M.
 The principal cause of death and related causes of importance were as follows:
Apoplexia, Cerebral
 Date of onset 12/1

Other contributory causes of importance:
Chronic Hypertension
arteriosclerosis

Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

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.
 (Address) Washington Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

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 10-9-39

....., Registered Apprentice No.

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 140 109

Date Filed 11240

Signed.....

Philip A. Jenckel

Licensed Embalmer No. 2936

P. O. Address Von Buena

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

444 #2
Do not use this space.

1. PLACE OF DEATH

(a) County Reynolds Registration District No. 1108
(b) Township Wedge Primary Registration District No. 3463 Registered No. _____
(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 Charles Senevay

(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) Wed

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 _____ mln.
63 9 11

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 12-10-1939

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 12/14/1939 T. L. Piles Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 8 - 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 4 to Dec 8, 1939

I last saw him alive on Dec 8, 1939 Death is said to have occurred on the date stated above, at 11-15 m.

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

Date of onset _____

Other contributory causes of importance: _____

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 L. B. Piles M. D.

(Address) Ellington Ind

SUPPLEMENTARY

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.

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

Do not use this space.

1. PLACE OF DEATH

- (a) Home
- (b) Jail
- (c) Hospital

Registration District No.

Primary Registration District No.

Register

- (d) Street No.
- (e) If death occurred in the place of institution, give the name of the institution and the date of death.

2. PRINT FULL NAME

(a) Residence No. (Last place of abode, if not in family, give street or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED, DIVORCED (write the status)	6. DATE OF BIRTH (MONTH, DAY AND YEAR)
7. AGE (YEARS AND MONTHS)	8. MARRIED, WIDOWED, OR DIVORCED (DATE OF RE-MARRIAGE)

9. OCCASION OF DEATH

10. PLACE OF DEATH

11. CAUSE OF DEATH

12. MANNER OF DEATH

5-44442

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF HEALTH
 COLUMBIA, MISSOURI