

FILED APR 1 1948

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

11934

Do not use this space.

1. PLACE OF DEATH

(a) County Pennscoot Registration District No. 653
 (b) Township Brazzodocis Primary Registration District No. 5871
 (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.

Registered No. 14

2. PRINT FULL NAME

Billie Ray Risner
 (a) Residence, No. Deering 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)
Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Infant6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 30 40

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 0 10

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
 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)
Deering Mo13. NAME Homer Risner14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Gloucester Mo15. MAIDEN NAME Meda Forman16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Ark. Mo17. INFORMANT (ADDRESS)
Homer Risner Deering18. BURIAL, CREMATION, OR REMOVAL PLACE Culp Brazzodocis Mo DATE 2-10 194819. FUNERAL DIRECTOR (NAME) (ADDRESS)
Friends20. FILED 2-9- 1948

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 9 194822. I HEREBY CERTIFY, That I attended deceased from Birth (1-30-40) 1940I last saw him alive on Feb 7 1948. 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:

Peternus NeonatorumDate of onset
1-30Other contributory causes of importance:
Prematurity - (8 mo)

Name of operation..... Date of.....

What test confirmed diagnosis? Teac 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..... 1948

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) William J. Smith, M. D.946 (Address) Deering Mo

Local Registrar.

Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

3-40-5

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11934

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 653

Primary Registration District No. 3871

Registrar's No. 14

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Permisic
(b) City or town Briggadoon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

3. (a) PRINT FULL NAME Billie Ray Resner

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
10 h. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 3/9/40 (b) Pearl Kelley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A. ? years

DEATH CERTIFICATION

20. DATE OF DEATH Month Feb day 9
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) (e) Means of injury

23. Signature Wm F Pett (M. D. or other)

Address Henrietta Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

11934 (1940)