

-11-10-39
5-17-39
P I X21492

Filed JUL 17 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21484

Registration District No. 171 Primary Registration District No. 4100 Registrar's No. 13

1. PLACE OF DEATH:
(a) County. Chariton
(b) City or town. Keosauqua
(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. 2470 1/2 St
years, months or days

3. (a) PRINT FULL NAME SAMUEL M. WHITE
3. (b) If veteran, name war. WWI
3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced. Married
6. (b) Name of husband or wife Louise White
6. (c) Age of husband or wife if alive. 68 years

7. Birth date of deceased Jan 26 1871
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 11
If less than one day hr. min.

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

10. Usual occupation Retired merchant
11. Industry or business Operated Grocery Store

12. Name Robert White
13. Birthplace Virginia
(City, town, or county) (State or foreign country)

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

16. (a) Informant Louise White
(b) Address Keosauqua
17. (a) Burial (b) Date thereof June 9 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keosauqua
18. (a) Signature of funeral director Alfred J. Barrett
(b) Address Keosauqua Mo
19. (a) 670 1/2 St (b) Mrs Ray Sandree
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State. Mo (b) County. Chariton
(c) City or town. Keosauqua
(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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 6
year 1940 hour 4 minute P M.
21. I hereby certify that I attended the deceased from May 26, 1940, to June 6, 1940
that I last saw him alive on June 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) None

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?
159 (Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Carl C. Meyer (M. D. or other) 1
Address Keosauqua Mo Date signed 6/10/40

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-15-40

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 H. O. Barnett
Licensed Embalmer No. 3046
P. O. Address Keytesville 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21484
Registrar's No. 3

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 171

Primary Registration District No. 4100

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

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Keosauville
(If outside city or town limits, write frontage 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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Samuel M. White

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

4. Sex m 5. Color or race white 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Jan 26 1869
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 11 If less than one day _____ hr _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-5-40 (b) Mrs Key Pauline
(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.

20. DATE OF DEATH: Month June day 6
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 _____ 19 _____
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?
(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Carl C. Wegener (M.D. or other) _____
Address Keosauville _____

SUPPLEMENTAL COPY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

