

STANDARD CERTIFICATE OF DEATH

State File No. 22946

Registration District No. 110

Primary Registration District No. 4487

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Scotland
(b) City or town Memphis Mo.
(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 2
(Specify whether

In this community years, months or days

3. (a) PRINT FULL NAME H.P. Flick 470

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

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

6. (b) Name of husband or wife Mrs. Emma Flick 6. (c) Age of deceased wife if alive dead years

7. Birth date of deceased Feb 7 1856
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days 14 If less than one day hr. _____ min. 0

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Sylvanus Flick

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

14. Maiden name Sarah D. Carberry

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

16. (a) Informant Mrs. Ruby Rockhold

(b) Address Memphis Mo.

17. (a) _____ (b) Date thereof June 26 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. Moriah Cem.

18. (a) Signature of funeral director W. S. Shuttling

(b) Address Kalasha St.

19. (a) 6/25/40 (b) E. E. Jarnish
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scotland

(c) City or town Memphis
(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 23rd, 1940
year _____ hour 4.00 minute A.M.

21. I hereby certify that I attended the deceased from June 22nd
in 1940 to June 23, 1940

that I last saw him alive on June 22nd, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Intestinal Obstruction

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy NONE

Duration

PHYSICIAN

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)
(e) Means of injury _____

23. Signature E. E. Jarnish (M. D. or other) _____

Address Memphis, Mo. Date signed 6/25/40

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

127B

RECEIVED

District Health Officer No. 10

District File Number 7-40-1398

Date Filed JUL 11 1940

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

Otto Lutting

Registered Apprentice No.

working under my personal supervision.

Signed

Otto Lutting

Licensed Embalmer No. 2965

P. O. Address. *Kahoka 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. **22946**
Registrar's No. **94**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **810**

Primary Registration District No. **4488**

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

1. PLACE OF DEATH:

(a) County **Scotland**
(b) City or town **Memphis**
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Scotland**
(c) City or town **Memphis**
(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.

3. (a) PRINT FULL NAME

HENRY P.

3. (c) Social Security No. _____

4. MEDICAL CERTIFICATION

20. DATE OF DEATH Month **June** day **23**
year **1940** hour _____ minute _____ M.

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

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 **84** Months **4** Days **16** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) **6-25-1940** (b) **E. E. Parrish**
(Date received local registrar) (Registrar's signature)

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?
While at work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature **E. E. Parrish** (M. D. or other)
Address **Memphis** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22946⁷

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 810

Primary Registration District No. 4488

Registrar's No. _____

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

1. PLACE OF DEATH: Scotland
 (a) County Scotland
 (b) City or town Memphis
 (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 _____ (Specify whether)
 years, months or days

3. (a) PRINT FULL NAME H. P. Flick
 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 wid
 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 84 Months 4 Days 16 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 _____

43. 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)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 6 day 23 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: Intestinal Obstruction

Due to: Intestinal Paralysis
NMB

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 E. E. Parrish (M. D. or other) _____

Address Memphis _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY