

S. No. 2  
4-13-40  
5-17-39  
P1 X2315

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27976

SEP 16 1940 85  
Registration District No.

Primary Registration District No. 1001

State File No.  
Registrar's No. 874

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

1. PLACE OF DEATH:  
(a) County: BUCHANAN  
(b) City or town: ST. JOSEPH  
(c) Name of hospital or institution: STATE HOSPITAL No. 2  
(d) Length of stay: In hospital or institution 6 mo + 28 days  
In this community 6 mo 28 da.  
years, months or days

3. (a) PRINT FULL NAME: Wesley Childers  
(b) If veteran, name war: -  
(c) Social Security No.: None

4. Sex: male  
5. Color or race: white  
6. (a) Single, widowed, married, divorced: married  
(b) Name of husband or wife: Wesley Childers  
(c) Age of husband or wife if alive: unk years  
7. Birth date of deceased: March 22 1863  
(Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 16  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation: Farmer

11. Industry or business:  
12. Name: Richard Childers  
13. Birthplace: Indiana  
14. Maiden name: Elizabeth Ann Black  
15. Birthplace: Indiana

16. (a) Informant: Records State Hosp # 2  
(b) Address: St. Joseph, Mo  
17. (a) Removal (b) Date thereof: 8-11-40  
(c) Place: burial or cremation: Lemons Mo.

18. (a) Signature of funeral director: Green E Kent  
(b) Address: Green City Mo  
19. (a) 8/19/40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: Putnam  
(c) City or town: Lemons  
(d) Street No.: \_\_\_\_\_  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

20. DATE OF DEATH: Month August day 8  
year 1940 hour 4 minute 35 P. M.  
21. I hereby certify that I attended the deceased from January 10, 1940 to August 8, 1940  
that I last saw him alive on August 8, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease  
Duration: 8-2-40  
Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: none done  
Of operations: none done  
Of autopsy: none done  
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): no  
(b) Date of occurrence: \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(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: D.P. Johnson (M. D. or other) 1 M.D.  
Address: State Hosp # 2 Date signed: 8-8-40

**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.....

*Archibald Wade*

Licensed Embalmer No.....

*3037*

P. O. Address.....

*Green City, 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, fact should be so stated above.**