

OCT 10 1940

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 242

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
State Hospital # 1  
(If not in hospital or institution, write street number or location) 3  
(d) Length of stay: In hospital or institution 3 mo. (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME JENNIE VEKNER  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. none

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: Years 90 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

12. Name D.K.

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

14. Maiden name D.K.

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

16. (a) Informant State Hospital # 1

(b) Address Fulton Mo.

17. (a) Burial (b) Date thereof Sept. 13 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Atterville Mo

18. (a) Signature of funeral director L. H. Parker

(b) Address Atterville Mo

19. (a) 9/21/40 (b) R. N. Creve (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Cooper  
(c) City or town Atterville Mo. (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 Sept. day 21 year 1940 hour 3 minute 7 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw her alive on Sept 21, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Broncho Pneumonia 6 days

Due to Fracture of R. Femur

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? 10/10

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

23. Signature R. N. Creve (M. D. or other) \_\_\_\_\_

Address Fulton Mo Date signed 9/21/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1948  
99

**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.....

*myself*

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*F. F. Parker*

Licensed Embalmer No. *3840*

P. O. Address *Otterville 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 31564

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Sulton  
(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) (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Jessie Varner

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced S

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 90 Months \_\_\_\_\_ Days \_\_\_\_\_ 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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 Sept day 21  
year \_\_\_\_\_ 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 Bronchitis pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

3 days

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) accident

(b) Date of occurrence Sept. 15, 1940

(c) Where did injury occur? Sulton Mo. State Hospital (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Fell out of bed in state hospital #1

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

23. Signature H. K. Pope (M. D. or other) \_\_\_\_\_

Address Sulton Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

