

No. 2
11-10-39
-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35908

State File No. _____

FILED NOV 25 1940

Registration District No. 683

Primary Registration District No. 4359

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Rural - Postage Come To
(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 no (Specify whether 2)

In this community 13 yrs
years, months or days

3. (a) PRINT FULL NAME Galord Sharron Deprow

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

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

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

7. Birth date of deceased Oct 26 - 1940
(Month) (Day) (Year)

8. AGE: Years no Months no Days 5 If less than one day hr. min.

9. Birthplace Tallapoosa (City, town, or county) no (State or foreign country)

10. Usual occupation ✓

11. Industry or business ✓

12. Name Roy Deprow

18. Birthplace Walden Mo (City, town, or county) (State or foreign country)

14. Maiden name Martha Deprow

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

16. (a) Informant Roy Deprow

(b) Address Tallapoosa

17. (a) Burial (b) Date thereof 10-30-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanfill cemetery

18. (a) Signature of funeral director T. B. Knight

(b) Address Parma Mo

19. (a) 10-31-40 (b) Dr. Gouphard
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

New Madrid
(a) State Missouri (b) County White

(c) City or town Rural - Tallapoosa Mo
(If outside city or town limit, write "RURAL")

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30
year 1940 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct 26-40
19 Oct 30 19 40

that I last saw him alive on Oct 29 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Pernicious Vomiting

Due to Possible Pyloric Stenosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 15 1/2"

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? 534

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

28. Signature Dr. Gouphard (M. D. or other) _____

Address Parma Date signed 10/31/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. _____

District File No. 1140-168

Date Filed 11/12/40

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 _____

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.