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FEB 10 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4778

Registration District No. 908

Primary Registration District No. 4579

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Mtn. Grove, Mo.
(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 Wright
(c) City or town Mtn. Grove, 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.? ~~_____~~ 0 years.

3. (a) PRINT FULL NAME Linton C. Paul

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 Emma Waters 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 31 1856
(Month) (Day) (Year)

8. AGE: Years 85 Months 9 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Paul

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

14. Maiden name Sellers

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

16. (a) Informant Bill Paul

(b) Address Mtn. Grove, Mo.

17. (a) Burial (b) Date thereof Jan. 23 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Long Star

18. (a) Signature of funeral director Russell Barber
(b) Address Mtn. Grove, Mo.

19. (a) 1-23-41 (b) Bernice Madamery
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. 23 day _____
year 1941 hour 10:15 minute 15 P.M.

21. I hereby certify that I attended the deceased from Jan 6
1941 to Jan 23 1941
that I last saw him alive on Jan 21 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Duration 1 mo

Due to Chro. Interstitial Nephritis and Arteriosclerosis

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

Major findings: _____
Of operations 121
Of autopsy _____
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 N. V. France (M. D. or other) _____
Address Mtn. Grove, Mo. Date signed 1/31/41

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4778
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. 908

Primary Registration District No. 4549

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

ROWLETT MOORE

1. PLACE OF DEATH:
(a) County Wright
(b) City Portland Grove
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Linton C Paul
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 _____ year

7. Birth date of deceased Mar 31 1856
(Month) (Day) (Year)

8. AGE: Years 84 Months 9 Days 22
If less than one day _____ h. _____ 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 _____
(City, town, or county) (State or foreign country)

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) 5-29-41 (b) Berrie Montgomery
(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 Jan day 23
year _____ 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?

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

23. Signature N G. Frame (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY

