

FILED JUN 10 1941

STANDARD CERTIFICATE OF DEATH

State File No. 19192

Registration District No. 836

Primary Registration District No. 4507

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Bernie Mo.  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard Mo.  
(c) City or town Bernie  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29  
year 1941 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 26 - 1941 to May 29 - 1941  
that I last saw him alive on May 29 - 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death: Double Labor Duration  
following measles  
Due to \_\_\_\_\_

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

Major findings:  
Of operations: \_\_\_\_\_  
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?  
8/13 (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. S. Davis (M. D. or other) \_\_\_\_\_  
Address Bernie Mo. Date signed 5/31/41

3. (a) PRINT FULL NAME Donald Dean Flanery

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

4. Sex male 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 Sept - 30 - 1938  
(Month) (Day) (Year)

8. AGE: Years 2 Months 7 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Baby

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

12. Name Bill Flanery

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

14. Maiden name Pauline Wicks

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

16. (a) Informant Mother Carrie Wicks

(b) Address Bernie

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May - 30 - 41 (Month) (Day) (Year)

(c) Place: burial or cremation Bernie County

18. (a) Signature of funeral director Bernie Funeral Home

(b) Address Campbell Mo.

19. (a) 6/1/41 (Date received local registrar) (b) Laura Hopkins (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

3  
1  
0

RECEIVED

District Health Officer No. \_\_\_\_\_

District File Number 641-25

Date Filed 6/9/41

**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 none  
\_\_\_\_\_, 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.**