

DEPARTMENT OF THE CENSUS  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JUL 11 1941  
4.49

Registration District No. ....

Primary Registration District No. 5618

Registrar's No. ....

1. PLACE OF DEATH:  
(a) County LACLEDE  
(b) City or town RURAL OSAGE TWP  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
LEBANON R. 4.  
(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 TIME!  
years, months or days

2. USUAL RESIDENCE OF DECEASED: 53  
(a) State Mo (b) County LACLEDE 0  
(c) City or town Rural LEBANON 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. 4.  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME JOHN R WRINKLE  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month JUNE day 18  
year 1941 hour 4 minute 30 P.M.

4. Sex MO 5. Color or race W  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife Quallan JAMES  
6. (c) Age of husband or wife if alive 73 years  
7. Birth date of deceased May 28 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 4, 1941, to June 4, 1941;  
that I last saw him alive on June 3, 1941;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>NO</u>	<u>20</u>	hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage  
Due to hypertension  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Duration 4 days  
Underline the cause to which death should be charged statistically. unknown

10. Usual occupation FARMER

Major findings: none  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

MOTHER FATHER  
12. Name JAS. WRINKLE  
13. Birthplace TENNI  
(City, town, or county) (State or foreign country)  
14. Maiden name EMMA CLAY  
15. Birthplace TENNI  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Chas Nurse

22. If death was due to external causes, fill in the following:

(b) Address LEBANON Mo

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) BURIAL (b) Date thereof ✓  
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation LEBANON Mo

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

18. (a) Signature of funeral director PALMER'S 444

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(b) Address LEBANON Mo

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

19. (a) 6-20-41 (b) James L. Hope  
(Date received local registrar) (Registrar's signature)

23. Signature James L. Hope (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 6/19/41

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

53  
0  
0

RECEIVED

District Health Officer No. 7,

District File Number 7-41-115-9

Date Filed 7-10-41

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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

*D. Palmer*

Licensed Embalmer No. 1161

P. O. Address Lebanon 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.**

Registration District No. 449

Primary Registration District No. 5618

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

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

1. PLACE OF DEATH: Laclede

(a) County \_\_\_\_\_

(b) City or town \_\_\_\_\_  
(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)

3. (a) PRINT FULL NAME John R. Wrinkle

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 m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_  
(Day) (Year)

7. Birth date of deceased May 28 1861  
(Month) (Day) (Year)

8. AGE:	Years	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 \_\_\_\_\_

MOTHER FATHER {

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 6-20-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) Aug 17 41 (b) J. M. Combs  
(Date 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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 18  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ 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 \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place)

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

