

4139

Registration District No. 229

Primary Registration District No. ~~229~~

Registrar's No.

1. PLACE OF DEATH:

(a) County Lafayette  
 (b) City or town Bourbon, 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

3. (a) PRINT FULL NAME WILLIAM L. WHITE

3. (b) If veteran, name war   
 3. (c) Social Security No. 499-03-2675

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

6. (b) Name of husband or wife   
 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased 11-30-1891  
 (Month) (Day) (Year)

8. AGE: Years 49 Months 8 Days 10  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

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

MOTHER FATHER { 12. Name Louis White  
 13. Birthplace Unknown (City, town, or county) (State or foreign country)  
 14. Maiden name Missouri BURRIS  
 15. Birthplace Jacksonville, Tenn. (City, town, or county) (State or foreign country)

18. (a) Informant Mrs. Mrs. Steen  
 (b) Address Sullivan, Mo.

19. (a) (Burial, cremation, or removal)  (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
 (c) Place: burial or cremation Bourbon, Mo.

18. (a) Signature of funeral director Albert E. Long  
 (b) Address Bourbon, Mo.

19. (c) Aug 12-41 (Date received local registrar) (b) C. W. Adams (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette  
 (c) City or town Bourbon (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 Aug. day 10 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 8 to 10, 1941, that I last saw him alive on 8 to 10, 1941, and that death occurred on the date and hour stated above.  
 Immediate cause of death Starvation

Due to Morbidity of Digestive Functions

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

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

Major findings: Of operations None  
 Of autopsy None

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 E. L. Hume (M. D. or other)  
 Address Bourbon, Mo. Date signed 8-12-41

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

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

221492

RECEIVED

District Health Officer No. 5,

District File Number 8811919

Date Filed .....

---

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 Albert Long

Licensed Embalmer No. 3604

P. O. Address Courbon 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31425  
Registrar's No. ....

Registration District No. 229 Primary Registration District No. 4139

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

1. PLACE OF DEATH:  
(a) County Crawford  
(b) City or town Bourbon  
(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 William L. White  
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 w  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased. 11-30-1899  
(Month) (Day) (Year)

8. AGE: Years 49 Months 8 Days ..... (If less than one day..... 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.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....  
(b) Address.....

17. (a) buried at Bourbon mo. Date thereof..... (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a) Aug 12 1941 CW Adams (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 Aug year 1941 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

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?.....

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

23. Signature..... (M. D. or other).....  
Address..... Date signed.....

SUPPLEMENTARY

S-31425 1941

2