

No. 2  
4-41  
7-13  
1943

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

35985

State File No. ....

NOV 12 1943

Registration District No. 341

Primary Registration District No. 3075

Registrar's No. 44

1. PLACE OF DEATH:

(a) County STODDARD

(b) City or town DEXTER  
(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 MISSOURI (b) County STODDARD

(c) City or town DEXTER  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME IRA WHITE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 4  
year 1943 hour 7 minute 45 A.M.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife ZOE H. WHITE

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased SEPT 4 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 1 1942 to Oct 7 1943  
that I last saw him alive on Oct 3 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

73 1 0 hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma of Lungs

Duration \_\_\_\_\_

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

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

10. Usual occupation RETIRED MERCHANT

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

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

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

12. Name W. F. WHITE

Major findings: Of operations \_\_\_\_\_

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

Of autopsy NO

14. Maiden name MARY JEAN

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

16. (a) Informant MRS. ZOE H. WHITE

(b) Address DEXTER, MO.

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

17. (a) BURIAL (b) Date thereof 10-6-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) NO

(c) Place: burial or cremation DEXTER CEMETERY

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

18. (a) Signature of funeral director BLANKENSHIP STRICKLAND

(b) Address DEXTER, MO.

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

19. (a) 11-1-1943 (b) NORA SMITH  
(Date received local registrar) (Registrar's signature)

(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 S. S. Hawn (M. D. or other) \_\_\_\_\_  
Address Dexter Mo. Date signed 11/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

1134

RECEIVED

District Health Office No.

District File Number 1143-1

Date Filed 11-11-42

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. 3479

P. O. Address Sever, Md

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
NOV  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Dexter  
(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 Ira 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 married

6. (b) Name of husband or wife Zoe White 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 4  
(Month) (Day) (Year)

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ (less than one day) \_\_\_\_\_ 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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

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

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

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

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

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

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 Oct day \_\_\_\_\_  
year 1943 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

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

MOTHER FATHER

35985