

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 27 1947
Registration District No. 220

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 221

Primary Registration District No. 5723

1. PLACE OF DEATH:

(a) County Macon
(b) City or town rural Chariton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Macon 61
(c) City or town rural 6
(If outside city or town limits, write "RURAL")
(d) Street No. College Mound Mo. 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Wilbur M. White

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MO

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept. 17. 1906

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

40

10

6

hr. _____ min.

9. Birthplace

Macon Co., Mo.

(City, town, or county)

(State or foreign country)

10. Usual occupation

labor

11. Industry or business

William S. White

12. Name

Macon Co., Mo. 6

(City, town, or county)

(State or foreign country)

14. Maiden name

Georgia Leathers

15. Birthplace

Macon Co., Mo. 7

(City, town, or county)

(State or foreign country)

16. (a) Informant

Mr. Wade Marshall

(b) Address

Bevier Mo.

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

7/25/47

(Month) (Day) (Year)

(c) Place: burial or cremation

College Mound Mo.

18. (a) Signature of funeral director

Stephens Gooding

(b) Address

Macon, Mo.

19. (a) 8-18-47

(Date received local registrar)

(b) Ruth McNeely

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1947 hour _____ minute 5 A. M.

21. I hereby certify that I attended the deceased from July 22 to July 23 1947, to July 23 1947, and that death occurred on the date and hour stated above.
Duration _____

Immediate cause of death tuberculosis

Due to complication cold and asthma

Due to _____

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

Major findings:

Of operations _____

Of autopsy no 138

PHYSICIAN

Underline the cause of death which should be certified as a **PREVENTABLE** disease

ADDITIONAL INFORMATION REQUESTED

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 J. L. Trippear (M. D. or other) _____

Address College Mound Mo. Date signed _____

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 8-47-1131
Date filed AUG 25 1947

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 James C. Cleaver Registered Apprentice No. 515
working under my personal supervision.

Signed A. H. Stephens
Licensed Embalmer No. 3057
P. O. Address Macon 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.

Primary Registration District No. 5723

Registrar's No.

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Rural
 (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 _____
 In this community _____
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Wilbur 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 wid

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

7. Birth date of deceased _____ (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 _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(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 July day 23
 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above.
 Immediate cause of death T.B. LUNGS

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-28327

J. L. Tupper M.L.
College House