

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

FORM 1-12-33 I X14023

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

7848
Do not use this space.

FILED MAR 6 - 1940 20

1. PLACE OF DEATH
 (a) County Putnam Registration District No. 720
 (b) Township Liberty Primary Registration District No. 5957
 (c) City..... (d) Street No..... Registered No. 2
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Minear
 (a) Residence, No. Armonia Ave Rural (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Sarah Minear</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>2-20-1846</u>				
7. AGE	YEARS <u>93</u>	MONTHS <u>11</u>	DAYS <u>8</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)			
				11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Iowa</u>				
FATHER	13. NAME <u>Samuel Minear</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>			
MOTHER	15. MAIDEN NAME <u>Parthenia Rhodes</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Pennsylvania</u>			
17. INFORMANT (ADDRESS) <u>Johnnie Minear</u> <u>Livonia Mo</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St John</u> DATE <u>Jan 31 1940</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>P. B. Husted & Son</u> <u>Unionville Mo</u>				
20. FILED <u>3-1</u> 19 <u>40</u> <u>E. C. McCellan</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>Jan 28 1940</u>	
22. I HEREBY CERTIFY That I attended deceased from <u>Jan 1 1940</u> to <u>Jan 28 1940</u> I last saw him alive on <u>Jan 27 1940</u> Death is said to have occurred on the date stated above, at <u>4:30 pm</u> The principal cause of death and related causes of importance were as follows: <u>Pneumonia (Bronch)</u> <u>suppurated</u> <u>Fever</u>	
Other contributory causes of importance: <u>None</u>	Date of onset
Name of operation.....	Date of.....
What test confirmed diagnosis?.....	Was there an autopsy?.....
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19..... Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.	
Manner of injury.....	Nature of injury.....
24. Was disease or injury in any way related to occupation of deceased? <u>no</u> If so, specify..... (Signed) <u>P. V. Hart</u> M. D. <u>Coatsville Mo.</u>	

RECEIVED

District Health Officer No. 10

District File Number 3-40-522

Date Filed MAR 4 1940

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

Muel E. Husted

Licensed Embalmer No.

3304

P. O. Address

Mossville 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. 748
Registrar's No. 2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 720

Primary Registration District No. 2951

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

1. PLACE OF DEATH:

(a) County Putnam

(b) City or town Liberty
(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 Minear

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 _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

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

93 11 8 _____ 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) Mich 1st 40 (Date received local registrar) E.E. Mclellan (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Putnam

(c) City or town Rural
(If outside city or town limits write "RURAL")

(d) Street No. 4 mi west Sironia
(If rural, give location) Liberty Town.

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that 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 _____

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 P. J. Hart (M. D. or other)

Address Wentzville Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

