S. No. 2
M—5-43
5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Thompson

State File No. 36796

Registration District No. 336 Primary Registration District No. 6131 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Mtn View (Star Route)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ~~West-Plains-Hospital~~
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days
In this community 19 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Shannon
(c) City or town Mtn View (Star Route)
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Earnest T. Behrens
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 widowed
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 81 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Cigar Manufacturer
11. Industry or business
FATHER
12. Name unknown
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name unknown
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Albert Scritchfield
(b) Address Mountain View, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-26-47 (Month) (Day) (Year)
(c) Place: burial or cremation Sedialia, Mo.
18. (a) Signature of funeral director Duncan Funeral Home
(b) Address Mountain View, Mo.
19. (a) 10-14-47 (Date received local registrar) (b) Mabel Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25 year 1947 hour 1 minute 15 a.M.
21. I hereby certify that I attended the deceased from Aug 23, 1947, to Aug 25, 1947;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ~~[illegible]~~	[illegible]
Due to Diverticulitis	7 [illegible]
Due to ~~[illegible]~~ Carcinoma	
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 Maurice Thompson (M. D. or other) M.D.
Address West Plains Mo. Date signed 9/27/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District No. 104762
Date Filed 10-30-47

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 Joe R. Inman

Licensed Embalmer No. 4325

P. O. Address Mtn View 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.

No. 2B
5-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1102

Registration District No. 236 Primary Registration District No. 6131 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Mt View (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(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 Shannon
(c) City or town Mtn View (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 Earnest J. Behrens
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 81 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation Cigar mfg.
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Albert Scritchfield
(b) Address Mt View, Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-26-47 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 11-12-47 (Date received local registrar) (b) Mabel Rose (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25 year 1947 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 — 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Maurice [illegible] (M. D. or other) MD
Address Thompson Date signed 11-2-47

36796