DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30091

REC'D SEP 21 1939

Registration District No. 734 — Primary Registration District No. 6018 B — Registrar's No. 891

1. PLACE OF DEATH
(a) County St Francois
(b) City or town Flat River (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 years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Francois
(c) City or town Flat River (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

3. (a) PRINT FULL NAME THELMA LOUISE QUEEN 5b
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased March 15, 1939 (Month) (Day) (Year)
8. AGE: Years ____ Months 4 Days 2 If less than one day ____ hr. ____ min.
9. Birthplace FLAT RIVER (City, town, or county) ____ (State or foreign country)
10. Usual occupation ____
11. Industry or business ____
FATHER 12. Name FRANCIS QUEEN
FATHER 13. Birthplace WASHINGTON (City, town, or county) COUNTY MO (State or foreign country)
MOTHER 14. Maiden name BERNICE LAWSON
MOTHER 15. Birthplace St Francois Co (City, town, or county) MO (State or foreign country)
16. (a) Informant's own signature Francis Queen
(b) Address FLAT RIVER MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-39 (Month) (Day) (Year)
(c) Place: burial or cremation St Francois County
18. (a) Signature of funeral director Joe Diemer
(b) Address FLAT RIVER MO
19. (a) 8/18/39 (Date received local registrar) (b) O Stewart (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17 year 1939 hour 4 minute 30 A. M.
21. I hereby certify that I attended the deceased from Aug 16, 1939, to Aug 17, 1939, that I last saw her alive on Aug 16, 1939, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death OTITIS Media	
Dysentery	
Due to upper respiratory infection	
Type of organism was determined	
Due to N.M.R.	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy none

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 C. H. Eppleberry (M. D. or other) MD
Address Flat River MO Date signed 8-17-39

(Licensed Embalmer's Statement on Reverse Side)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 G. J. Claywell

Licensed Embalmer No. 3706

P. O. Address Bonne Terre Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.