

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33402

Registration District No. 994

Primary Registration District No. 4465

Registrar's No. 895

1. PLACE OF DEATH: 2
(a) County St. Francois County
(b) City or town Esther, Mo.
(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 Little Melvin Lee Weikens 452
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White Cauc
6. (a) Single, widowed, married, divorced Chel
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive Chel years
7. Birth date of deceased Sept. 18 1939
(Month) (Day) (Year)

8. AGE: Year Born dead Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Chel

11. Industry or business _____

MOTHER FATHER
12. Name Mrs. Clyde A. Williams 0
13. Birthplace Crystal City, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Armeda Mason
15. Birthplace Marion, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clyde A. Williams
(b) Address Esther, Missouri

17. (a) Three Rivers (b) Date thereof Sept 18 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Three Rivers Cemetery

18. (a) Signature of funeral director Alvin W. Hoover
(b) Address Flat River, Mo.

19. (a) 9-18-39 (b) C. B. HERRAR M.D.
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 18th
year 1939 hour Dead in uterus one wk
21. I hereby certify that I attended the deceased from 9-18-39
_____ 19 _____ to 9-18- 19 39
that I last saw h. Born dead _____ 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Dont know. Probably
Dead one week before
Due to birth
Due to _____

Other conditions Decomposition at birth
(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 C. B. HERRAR (M. D. or other) _____
Address Flat River Mo Date signed _____

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.

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

Aloin W. Hood

Licensed Embalmer No. *2780*

P. O. Address *Flat River, 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.