

MARGIN RESERVED FOR BINDING

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 8 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44492

Registration District No. 771

Primary Registration District No. 4462.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Francois 2

(b) City or town Bismarck, 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)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County St. Francois

(c) City or town Bismarck
(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

3. (a) PRINT FULL NAME James Devine

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

20. DATE OF DEATH: Month Dec day 21
year 1939 hour 10 minute 30 P. M.

4. Sex Male

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 6 5 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6th Dec, 1939, to Dec 21, 1939; that I last saw him alive on Dec 24, 1939; and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>6</u>	<u>5</u>	hr. _____ min. _____

Immediate cause of death Influenza Duration 15 days

Due to hepatic obstruction hepatic

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

Due to _____

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER

12. Name William Devine 4

13. Birthplace England
(City, town, or county) (State or foreign country)

14. Maiden name Devine

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature _____

(b) Address _____

17. (a) Burial (b) Date thereof 12 23 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Home

18. (a) Signature of funeral director J. S. Boyer & Son

(b) Address Leadwood, Mo

19. (a) Dec - 23 - 39 (b) J. W. Gale
(Date received local registrar) (Registrar's signature)

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 Edward M. Coff (M. D. or _____)

Address Bismarck Mo Date signed 12-22-39

V. S. 50M-5-17-39
Rev. 5-17-39
U. S. G. P. 1 x1951

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

Bert L. Bay

Licensed Embalmer No.

3445

P. O. Address

Leadwood 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.